DEVELOPMENTAL QUESTIONNAIRE

This questionnaire asks you to respond to a series of questions about you and your family. This type of information is very helpful in making an accurate diagnosis. Please complete these forms as best you can. We will have the opportunity to discuss them in detail at your appointment.

TODAY'S DATE:

NAME	DATE OF BIRTH	AGE
WORK PHONE	HOME PHONE	
ADDRESS		
SPOUSE'S NAME	WORK PHONE	CELL PHONE

Referred by: Phone

Address

Primary Care Physician Phone

Address

Have you been seen by any of the professionals listed below for emotional/behavioral problems such as depression, anxiety, etc? Please check and list all that apply.

Psychiatrist ______

Primary Care Physician ______

Therapist ______

Psychologist ______

Please specify the type of treatment received:______

Why are you seeking professional help at this time?

______

______

Outpatient Treatment: Duration of treatment

Physician/therapist Address from to

______

______

Inpatient Treatment:

Facility Name Address Treating MD Duration of hospitalization

______

______

Medications used that helped:______

SOCIAL HISTORY:

Married: ____ No ____ Yes Divorced: ____ No _____ Yes # of marriages ______

Children: ____ No ____ Yes Ages_____________________________ # living with you ___

Do you currently use any type of drugs? _____ No _____ Yes If yes, what types of drugs and how much per day? ____

Do you currently drink alcohol? _____ No _____ Yes If yes, what type of alcohol and how much per day? ____

Any history of legal problems? Please Specify

____

____

List any stressful or traumatic events in your life which may have affected your development and ability to function (ie, birth of sibling, death in the family, divorce, illnesses, frequent school changes, witnessing a trauma).

Incident age comments

____

____

____

MEDICAL HISTORY:

Check all those that apply. In the extra space provided, please describe the condition, and specify the type of treatment received.

Asthma _____
Anemia _____
Seizures _____
Heart Problems _____
Thyroid Problems _____
Glaucoma _____
High Blood Pressure _____
Strokes/Heart Attacks _____

List any other existing or recent medical conditions treated

____

List Surgeries: Age Complications

____

____

List other Hospitalizations Age Reason Length of Stay

____

____

List any head injuries Age Loss of consciousness

____

List any allergies to medications ____

PRESENT MEDICAL STATUS

Are you in any way physically ill at this time? _____ No _____ Yes, If yes, please explain.

____

List current medications you are taking. Include dosage and reason. Include vitamin, herbs and over the counter.

____

____

Please use this space and any additional sheets for any additional information/comments you wish to share with us about you.

____

____

FAMILY PSYCHIATRIC AND MEDICAL HISTORY

Specify which family members suffer from metal health problems or listed medical problems.

	Relationship to patient	Medications(specify)	Hospitalizations
Depression			
Bipolar Disorder			
Anxiety Disorder			
Schizophrenia			
Anorexia/Bulimia			
Alcohol/Drugs			
ADHD			
Suicide attempt or completion			
OCD/Obsessive Compulsive Disorder			
Legal Problems			
Violent Behavior			
Heart Problems….What kind?			
Epilepsy/Seizures			
Thyroid Problems….. What kind?			
Other: specify type			