

ADULT VERSION

DEVELOPMENTAL NEUROBEHAVIORAL DATA BASE

NAME: _____ TODAY'S DATE: ____/____/____

BIRTHDATE: ____/____/____

AGE: _____

Name of person filling out questionnaire (if not patient): _____

The following questions deal with your reasons for seeking assistance, pregnancy, your developmental and medical history, performance in school, and your family history. Please fill this questionnaire in as much detail as possible. Feel free to make notes and provide as much additional information as is needed. If you have any school reports or previous assessments, bring these along. All of this information will be reviewed with you in detail, but it is helpful to have a complete and accurate record to start with. Thank you!

What are your expectations from this evaluation; what do you want to know?

CURRENT PROBLEMS (Please list the problem, when you first became concerned and what you think is the cause of the problem).

a)

b)

c)

d)

e)

f)

What things do you enjoy doing? _____

What things do you do well? _____

How do you get along with others? (*please describe*) _____

MEDICAL HISTORY

Have you ever had any serious medical illnesses? Yes No

If yes, please describe: _____

Have you ever had any hospitalizations or operations? Yes No

If yes, please describe:

Hospital Name, city & state	Date	Reason for hospitalization

Have you had any sporting or motor vehicle accidents? Do you have any of the following health problems? Please explain:

Do you have any of the following health problems? Please explain

Poor vision or eye problems?	Yes	No	
Repeated ear infections?	Yes	No	
Hearing loss?	Yes	No	
Sinus infections	Yes	No	
Throat infections	Yes	No	
Are teeth in good condition?	Yes	No	
Heart problems (heart murmur, irregular heart beat, high blood pressure)	Yes	No	
Pulmonary problems: bronchiolitis, bronchitis, pneumonia, asthma	Yes	No	
Chronic constipation	Yes	No	
Stomach aches, upset stomach, nausea, vomiting, digestion, constipation, diarrhea	Yes	No	
Kidneys, bladder, or urinary problems	Yes	No	
Muscle, bone, or joint problems	Yes	No	
Fractures	Yes	No	
Skin or hair problems	Yes	No	
Headaches	Yes	No	
Migraine Headaches	Yes	No	
Seizures	Yes	No	
Head injury	Yes	No	
Concussion	Yes	No	
Whiplash	Yes	No	
Loss of consciousness	Yes	No	
Multiple Sclerosis (M.S.)	Yes	No	
Stroke	Yes	No	
Brain Tumor	Yes	No	
Lupus	Yes	No	
A.I.D.S.	Yes	No	
Encephalitis	Yes	No	
Meningitis	Yes	No	

Syphilis	Yes	No	
Diabetes	Yes	No	
Seen a psychologist or psychiatrist	Yes	No	
Thyroid or other endocrine problems	Yes	No	
Anemia? Low white count	Yes	No	
Allergies	Yes	No	
Weight problem	Yes	No	
Poisoning	Yes	No	
Accidents	Yes	No	
Serious Injury	Yes	No	
Back pain	Yes	No	
Neck pain	Yes	No	
Jaw pain	Yes	No	
Dizziness	Yes	No	
Vision	Yes	No	
Hearing	Yes	No	
Sense of smell	Yes	No	
Sexual Activity	Yes	No	
Genetic conditions diagnosed by genetic testing	Yes	No	
Tobacco use	Yes	No	

Please list and describe any other problems that have not been addressed in the questions above: _____

	Yes	No	Please explain
Do you have a good appetite?	Yes	No	
Do you require any sort of special diet?	Yes	No	
Do you get enough exercise?	Yes	No	

How many hours of sleep a night do you get?

Week nights _____

Weekends and holidays _____

Do you have any of the following problems:

Do not like to go to bed	Yes	No
Can't fall asleep	Yes	No
Wake up in the middle of the night	Yes	No
Wander around in middle of the night	Yes	No
Afraid of the dark	Yes	No
Nightmares	Yes	No
Wakes up too early in the morning	Yes	No
Very hard to wake up	Yes	No
Snore	Yes	No
Have pauses or interruptions in breathing while asleep	Yes	No
Bedwetting	Yes	No
Fall asleep or gets drowsy during the day	Yes	No
Sleepwalking	Yes	No
Repetitive dreams	Yes	No
Limbs jerking wakes you up	Yes	No

Medication

Please list any medications that your are on at **present**. Include vitamins, over the counter, and herbal remedies:

Name of medication	When started?	Strength?	How many times a day?

If you have been on medications for psychiatric reasons, please include these on the medication lists in past medical history.

	Yes	No	Please explain
Are you using alcohol?			
Are you using drugs?			
Have you been abused or traumatized?			

EDUCATIONAL HISTORY

Last Grade completed: _____

Please list all schools that your child has attended:

	Name of School/Location	Dates Attended	GPA
Elementary School			
Middle School			
High School			
College/University BA/BS			
College/University MA/MS			
College/University Ph.D.			

SAT scores (if known): _____

Have you ever repeated or skipped a grade? Yes No

If yes, which grade? and what was the reason? _____

Have you ever been in a special tutoring class? Yes No

If yes, what kind of special class? what was the reason? _____

Did you ever have difficulty learning to read?	Yes	No
Do you have difficulty reading?	Yes	No
Do you read slowly?	Yes	No
Do you have problems understanding what you read?	Yes	No
Did you ever have any problems with spelling?	Yes	No
Do you rely on a spell checker to produce an adequate document?	Yes	No
Did you have difficulty writing book reports and term papers?	Yes	No
Is the conceptual act of writing difficult for you?	Yes	No
Is the mechanical act of writing difficult for you?	Yes	No
Do you read the Daily newspaper?	Yes	No
Do you read the Sunday newspaper?	Yes	No
Do you read magazines (number per month: _____)?	Yes	No
Do you read technical/professional material?	Yes	No
If you took a foreign language class, was this a difficult learning experience?	Yes	No
Did you ever have any problems learning math?	Yes	No

Have you been in any gifted or honors classes?

Have you ever failed a course?

Have you ever been told you have a learning disability?

What is your best subject in school? _____

What subject is hardest for you? _____

EMPLOYMENT HISTORY

Current Occupation:

- | | | |
|--------------------------------------|-----|----|
| 1. Student | Yes | No |
| 2. Full time (40 hr/week) employment | Yes | No |

Present employment/Job Title: _____

Current Employer: _____

How Long? _____

Number of Hours worked each week: _____

If Unemployed, How long? _____

Reason: _____

Job Difficulties:

Past Occupations (with dates):

LEGAL HISTORY

Are you involved in any litigation?

Have you ever been arrested?

DRIVING HISTORY

Do you currently have a driver's license?	Yes	No
Has your driver's license ever been taken away?	Yes	No
Have you ever been in an accident when you were driving?	Yes	No
Do you like to drive fast?	Yes	No
Have you ever been stopped by the police for speeding? # of times: _____	Yes	No
Have you ever been arrested for driving under the influence (DUI)?	Yes	No
Do you find it hard to wait at red lights?	Yes	No

OBSTETRICAL HISTORY (If you can please discuss with your mother)

How old was your mother when pregnant with you? _____

How many times was your mother pregnant before this pregnancy? _____

Were there ever any miscarriages or abortions? Yes No

If Yes, please indicate year and month of pregnancy:

Did your mother see a doctor for prenatal care? Yes No

If yes, please indicate which month of pregnancy prenatal care was started _____

During the pregnancy, how much weight did your mother gain? _____

If weight loss, how much? _____

Name of hospital in which you were born: _____

During your mother's pregnancy with you, did any of the following occur?

Please circle the answer:

Please explain:

Amniocentesis	Yes	No	
Bleeding or Spotting	Yes	No	
Placental Abruption	Yes	No	
Rashes	Yes	No	
Fevers or Infections	Yes	No	
Kidney Trouble	Yes	No	
High Blood Pressure	Yes	No	
Swelling of ankles	Yes	No	
Toxemia or Preeclampsia	Yes	No	
Low Salt Diet	Yes	No	
Water Pill (Diuretics)	Yes	No	
Sugar in Urine	Yes	No	
Rh Factor	Yes	No	
Sickle Cell	Yes	No	
Premature labor	Yes	No	
Maternal Illness	Yes	No	
X-rays	Yes	No	
Accident	Yes	No	
Hospital Stay	Yes	No	
Cigarettes	Yes	No	
Alcohol	Yes	No	
Maternal Drug Use	Yes	No	
Emotional or Other Stress	Yes	No	
Maternal Chronic Medical Illness	Yes	No	

Were any of the following medicines taken during the pregnancy?

Birth Control Pills	Yes	No
Prenatal vitamins	Yes	No
Prenatal calcium/iron	Yes	No
Medicine to keep baby (prevent labor)	Yes	No
Antibiotics	Yes	No
Anticonvulsants (for seizures)	Yes	No
Steroids (prednisone)	Yes	No
Sleeping pills	Yes	No
Antidepressants	Yes	No
Tranquilizers	Yes	No
Reducing pills	Yes	No
Any other medications? (specify)		

			Please explain
Was this a full term (9 month, 38 to 42 week) pregnancy?	Yes	No	<i>If no, please indicate what week of pregnancy baby was born _____</i>
Did your mother go into labor by herself?	Yes	No	<i>If no, was labor induced?</i>
Was delivery by Caesarian Section?	Yes	No	Reason for C-section?
How many hours was your mother in labor?	Yes	No	
Was the baby born head first?	Yes	No	<i>If not, what happened?</i>
Were forceps used?	Yes	No	<i>Not sure Don't know</i>
Was Vacuum extraction used?	Yes	No	

Apgar Scores _____ Don't know

Any other complications of delivery? *Please indicate yes or no.*

Premature rupture of membranes (water broke too early)	Yes	No
Doctor had to "turn" the baby	Yes	No
Twins or triplets	Yes	No

Hemorrhage	Yes	No
High blood pressure	Yes	No
Mother had postpartum depression	Yes	No

If another complication occurred that was not listed, please describe:

Did you have any of these problems after the delivery? *Please indicate yes or no.*

Put in incubator	Yes	No
Blueness or trouble breathing	Yes	No
Jaundice (yellow skin)	Yes	No
Convulsions	Yes	No
Did not feed well	Yes	No

Birth weight? _____

When did mother & baby leave hospital? _____

Specify if another problem occurred that was not listed _____

DEVELOPMENTAL HISTORY (If you can, please discuss with the person(s) who raised you)

If your parents kept a baby book, you might wish to check it to answer some of these questions.

Did you have any of the following problems?

Colic, excessive irritability, inconsolable crying	Yes	No
Did not sleep very much	Yes	No
Too stiff, arched back	Yes	No
Sleepy, lethargic – had to wake baby to feed it	Yes	No
Too floppy	Yes	No
Feeding problem	Yes	No
Breathing problem	Yes	No
Did not like to be held	Yes	No
Failure to Thrive	Yes	No

Specify if another problem occurred that was not listed:

When were you able to sit alone WITHOUT PROPPING OR HELP? _____

When did you start to walk WITHOUT HOLDING ON? _____

When did you start to babble? (bababa...gagaga) _____

When did first words (with meaning) appear? _____

When did you say short sentences like: "I want milk" or "go bye bye"? _____

Please explain:

By age 2 years, was your speech clear to other persons?	Yes	No	
Did you have trouble learning to speak?	Yes	No	
Were you different from your brothers or sisters or other children?	Yes	No	
Were you able to follow simple instructions?	Yes	No	
Did you have any problems chewing or swallowing food?	Yes	No	

How old were you when able to:

Ride a tricycle?

Ride a bicycle without training wheels?

Get dressed by self?

Tie shoelaces?

What hand do you prefer to use?

Are you more active, restless, or fidgety than others your age?

Yes No

If yes, when did you first notice this? _____

Do you have trouble controlling impulses?

Yes No

If yes, when did you first notice this? _____

Do you seem to be easily distracted and have trouble attending to chores, school work, work or TV?

Yes No

If yes, when did this start? _____

Were you ever told you were hyperactive or had ADD/ADHD?

Yes No

If yes, please explain

SENSORY HISTORY

Have you ever had: any of the following problems?	Yes	No	Sometimes
Avoids certain textures, such as sand, mud, foods, lotion			
Strongly dislikes having hair washed, combed or brushed			
Strongly dislikes having dirty hands			
Has trouble tolerating touching, hugging or cuddling			
Strongly dislikes having hair or fingernails cut			
Prefers to wear only certain types of clothes			
Frequently runs into or accidentally bumps objects or people			
Seems unaware of cuts, bumps or bruises			
Frequently walks on tiptoes			
Crawled with arched or fisted hands			
Over sensitive to sound (puts hands over ears)			
Becomes easily distracted by environmental sounds			
Has difficulty following directions			
Frequently chews on clothes or objects			
Avoids eating certain types of textures or foods			
Seems overly sensitive to smells			
Seems unaware of smells and tastes			
Craves tangy or zesty foods			
Get carsick frequently			
Avoid swinging, sliding or using playground equipment			
Seek out swinging			
Avoid trampolines			
Have poor balance			
Hold hands or body in unusual positions			

Have you ever had: any of the following problems?	Yes	No	Sometimes
Have difficulty with motor coordination			
Use too much or too little pressure with objects			
Avoid using vision to coordinate hand and body movements			
Have difficulty with puzzles, colors and shapes			
Blink excessively when trying to catch balls or balloons			

Any other sensory concerns that have not been listed? (*please describe*): _____

FAMILY HISTORY

Please fill in the following:

Relative	Age	Education	Occupation
Father			
Mother			

Please list brothers and sisters:

Brother/Sister	Age	Grade in School	Any learning problems?

List medical problems that run in family (including thyroid disease, diabetes, elevated blood pressure, heart problems, and cancer:

Does any blood relative have:	Yes	No	Please explain:
Anxiety			
Obsessions/Compulsions			
Panic			
Depression			
Bipolar Disorder			
Schizophrenia			
ADHD			
Impulsive, risk-taking behavior			
History of victimization or trauma			
Drug or alcohol abuse			
Suicidal behavior			
Tourette's syndrome			
Psychiatric Hospitalization			

Have any relatives had any other emotional difficulties, attention deficit disorder, or learning problems? Yes No

If yes, please describe _____

PLEASE LIST PROFESSIONALS INVOLVED, THEIR PHONE NUMBER AND FAX NUMBER:

(Note, in order to assure confidentiality, contact will not be made without an Authorization for Release of Information signed by the child's parent or guardian).

Name	Role	Telephone Number	Fax Number	Email Address

Interviewer Sheet

Describe anything in the person's life (even if it had nothing to do with the person) that caused unhappiness, nervousness or placed family members under special strain:

Death or loss of parent/sibling:

Abuse

Divorce of parents

Neglect:

Separation of parents

New residence

Family conflict

Family/Parent mental illness/disorder

Personal injury or illness

Change of schools

Family health problems

Family financial problems

Family legal problems

Loss of close friend

Other:

Draw Medical and Psychiatric Genogram as part of Family History