Center for Behavioral Health
University of Missouri – St. Louis

ADULT MEDICAL/DEVELOPMENTAL HISTORY

Please complete the following questionnaire as thoroughly as possible.

Name: _____ Today's Date: _____

Gender: _____ Sexual Identity: _____ Date of Birth: _____

Race/Ethnicity/Cultural Identity: _____ Age: _____

This form was completed by: _____

Address: _____

Telephone Number: _____

Email Address: _____

Presenting Concerns

1. Please list three main concerns you have:
   a.
   b.
   c.
2. How long ago did these problems begin? _____
3. Were there any important events that happened at about the same time that the problems began?
4. What do you think contributed to the problems?
5. What would you like to change about your present behavior and/or feelings?
6. What have you tried to do and how has this worked?

7. What is your current relationship status?

☐Single ☐Married ☐Committed Relationship
☐Remarried ☐Widowed ☐Separated
☐Divorced ☐Ethical Non-monogamy ☐Other (please specify) _____

8. List the dates of marriages and divorces, including current:

Spouse's Name	*Date of Marriage*	*Date of Divorce*

9. Are you in a long-term relationship? ☐Yes ☐No

10. If so, how long have you been in this relationship? _____

11. If you are divorced or separated, what factors do you think led to this change in your relationship?

12. Below, list all of the people with whom you are currently living, their relationship to you (e.g., partner, son, sister, adopted brother, etc.), and describe what that relationship is like.

Name	*Age*	*Relationship to you*	*How well do you get along?*

13. Please list others who you feel have an important impact on your life:

14. Do any of the people in your life have problems that concern you? ☐Yes ☐No
If so, please explain:

15. With whom do you feel you can talk these days if you have a problem?

16. Have you experienced any of the following? If yes, please explain.

☐Physical abuse

☐Sexual assault, sexual abuse

☐Emotional abuse

☐Death of someone close to you

☐Alcohol or drug abuse by a partner or close relative

☐Witnessed violence or abuse of others in the home

☐Serious illness or disability, either of yourself or a close relative

☐Criminal arrest or court proceedings

☐Other situations that have been traumatic

17. What's the name of your mother (or primary caregiver)? _____
    What is/was their occupation? _____
    How is their health? _____
18. What's the name of your father (or second primary caregiver)? _____
    What is/was their occupation? _____
    How is their health? _____
19. As a child, how did your parents reward you? _____
20. As a child, how did they discipline you? _____
21. How many children were there in your family when you were growing up? _____
    a. How many older sisters? _____ Older brothers? _____
    b. How many younger sisters? _____ Younger brothers? _____
22. If your parents are divorced, please indicate how old you were when they divorced and describe your reaction:

Developmental History

23. Did your mother receive prenatal care while pregnant with you?
☐Yes ☐No ☐Unknown

24. Did your mother take medication, or use alcohol, drugs, or tobacco while pregnant?

☐Yes ☐No ☐Unknown If yes, what, and what amount daily?

25. Complications of pregnancy included (check all that apply):

☐None	☐Diabetes	☐Premature birth
☐Cesarean Section	☐High Blood Pressure	☐Poor Nutrition
☐Breech Birth	☐Poor Emotional Health	☐Toxemia
☐Jaundice	☐Mother's Loss of Consciousness	
☐Other: _____		☐Unknown

26. Who was your main caretaker as an infant? _____

27. Did you need special medical help at birth? For example, did you have trouble breathing during or shortly afterwards, or stay in the NICU? ☐Yes ☐No
If yes, please explain: _____

28. Did you have medical problems during the first year? ☐Yes ☐No
If yes, please explain: _____

29. As a child, did you have difficulty with any of the following? (Check all that apply)

☐Pronouncing words correctly	☐Stuttering	☐Eating problems
☐Abnormal height or weight	☐Night Terrors	☐Bed-wetting
☐Sleepwalking	☐Thumb-sucking	☐Nail-biting
☐Unusual Fears	☐Sleep Problems	☐Other

Please explain any problems noted above:

30. What is the happiest memory of your childhood?

31. What is the saddest memory of your childhood?

32. At what age did you begin puberty? _____
    Describe any problems:

33. How did you feel about the changes that took place during puberty?

34. How did you learn about sex? _____

35. Do you have any sexual concerns? If yes, please explain:

Medical History

36. Please list below dates and reasons for any operations and hospitalizations:

Operation/Hospitalization	*Age at Time*	*Problems/Aftereffects*

37. Please indicate if you experienced any of the following, and the age at which they were experienced

☐Vision (wear glasses, etc.) Age _____ ☐Hearing (hearing aids, etc.) Age _____

☐Chronic ear infections Age _____ ☐Coordination problems Age _____

	Age		Age		Age
☐Allergies	____	☐Gall Bladder	____	☐Pneumonia	____
☐Anemia	____	☐German Measles	____	☐Polio	____
☐Appendicitis	____	☐GYN Disease	____	☐Rheumatic Fever	____
☐Asthma	____	☐Heart disease	____	☐Scoliosis	____
☐Blood Clots	____	☐Heart Murmur	____	☐Seizures	____
☐Blood Pressure	____	☐Hepatitis	____	☐Sickle Cell	____
☐Broken Bones	____	☐High Fevers	____	☐Sinusitis	____
☐Cancer	____	☐HIV	____	☐Skin Rashes	____
☐Chicken Pox	____	☐Hives	____	☐STD	____
☐COVID	____	☐Kidney Disease	____	☐T.B.	____
☐Dental	____	☐Liver Trouble	____	☐Thyroid	____
☐Diabetes	____	☐Lockjaw	____	☐Tonsilitis	____
☐Diphtheria	____	☐Measles	____	☐Typhoid Fever	____
☐Encephalitis	____	☐Meningitis	____	☐Whooping Cough	____
☐Fainting/Dizzy	____	☐Mumps	____	☐Other_____	____

38. Please list below any illnesses/long-term medical conditions.

Illness/Persistent Condition	*Age of Onset*	*Treatment*

39. Have you ever had a head injury, fainted, or lost consciousness? ☐Yes ☐No
If yes, please explain, and include your age when this occurred:

40. Please list below any serious accidents/falls that you have experienced.

Accident/Fall – what happened?	*Age at time*	*Treatment/Aftereffects*

41. Please list below any medications you are currently taking.

Medication	*Dose/Frequency*	*Reason prescribed*	*Side effects*

42. Do you take your medications regularly? ☐Yes ☐No

43. Date of last physical? _____
Name of your physician: _____

Mental Health History

44. Have you had mental health treatment before? ☐Yes ☐ No
    If yes, please list the professional, dates seen, reasons for treatment, and reason treatment was discontinued (e.g., symptoms resolved, finances, etc.).

Name of Mental Health Professional	*Dates Seen*	*Reason for Treatment*	*Reason Discontinued*

45. Have you ever received a mental health diagnosis (e.g., Major Depressive Disorder, Generalized Anxiety Disorder, ADHD, etc.) ☐ Yes ☐ No
    If yes, please list below.

Diagnosis	*Diagnosing Provider*	*Date*

46. Have you ever been hospitalized for a psychiatric condition? ☐Yes ☐No
    If yes, please list hospitalizations and reason/dates below.

Name of Hospital	*Dates Seen*	*Reason for Hospitalization*

47. On average, how many days each week do you drink alcohol? _____
    a. On a typical day when you drink, how many drinks do you have? _____
    b. What is the maximum number of drinks you have had on any one occasion during the past month? _____

48. Do you smoke cannabis or use any other cannabis products (also known as marijuana)? ☐Yes ☐No
    a. If yes, please describe your use.

49. Do you currently smoke tobacco or use nicotine products? ☐Yes ☐No
    a. If yes, for how long have you smoked tobacco? _____
    b. How much do you smoke daily? _____

50. Please describe any other past or current drug use:

51. Please indicate if anyone in your family has experienced any of the following conditions. Check the item and then state their relationship to you.

Condition ***Indicate who (e.g., child, mother, brother, etc.)***

☐ADHD/ADD _____
☐Alcohol Abuse _____
☐Anorexia/Bulimia/Eating Disorder _____
☐Anxiety/Nervousness _____
☐Autism _____
☐Bipolar Disorder _____
☐Dementia _____
☐Depression _____
☐Drug Abuse _____
☐Growth Problems _____
☐Intellectual Disability _____
☐Physical Disability (blindness, hearing, loss of limb) _____
☐Schizophrenia _____
☐Seizures/Convulsions/Epilepsy _____
☐Self-Harm _____
☐Specific Learning Disorder _____
☐Sudden Death _____
☐Suicide Attempt _____
☐Other illness, please explain _____

Academic/Occupational History

52. What is the last grade of schooling that you completed? _____
The name of the school you last attended: _____

53. What are/were your best subjects in school? _____
What are/were your worst subjects in school? _____

54. Have you ever had academic, cognitive, or psychological testing? ☐Yes ☐No
If yes, please bring to the appointment and complete the following:

Age	*Tested by Whom*	*Results of Testing*

55. Have you ever been diagnosed with a learning disability? ☐Yes ☐No
If yes, please explain in which areas: _____

55. Did you receive additional help in school? ☐Yes ☐No
If yes, please explain

56. Are you currently working? ☐Yes ☐No
If yes, what are you doing? _____

57. What kinds of jobs have you had in the past, and how did you feel about them?

58. If you have left any jobs or changed positions, what were the reasons?

59. What kind of work do you hope to do in the future? _____

Legal History

60. Are you currently, or have you ever been, involved with the criminal justice system?
☐Yes ☐No
If yes, at what age, and why? _____

61. Are you involved in any lawsuits or other legal actions at the present time?
☐Yes ☐No
If yes, please explain _____

Recreational/Personal History

62. How do you enjoy spending your time?

63. Please below list the leisure activities that you most enjoy:_____
_____

64. What social media do you use? _____

65. How much time do you spend on social media each day? _____

66. How much time do you spend playing video games each day? _____
Do you typically play ☐alone ☐with others online ☐with others in person

67. Are you a member of any religious denomination? ☐Yes ☐No
If yes, please state which and describe the role of religion in your life. _____
_____

68. Please list any organizations, clubs, teams, or groups with which you are involved (e.g., church, PTO, AA, NA, Children's Division, non-profit group, social organization, etc.)

69. What do you see as your strengths?

70. What do you see as your weaknesses?

71. What question/s are you hoping this evaluation will answer?

Please add any other information below that you feel is important in helping to understand you or your circumstances.

Thank you for taking the time to complete this form.