COMMUNITY
PSYCHOLOGICAL SERVICE
University of Missouri—St. Louis

ADULT MEDICAL/DEVELOPMENTAL HISTORY

Please complete the following questionnaire as thoroughly as possible.

Name:_____ Age: _____
Social Security Number:_____ Gender: _____
Race/Ethnicity:_____ Birth Date:_____

This form was completed by:_____ Today's Date:_____

Address: _____
_____

Presenting Concerns

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

Family Background

6. What is your current relationship status?
   ☐Single ☐Married ☐Committed Relationship
   ☐Remarried ☐Widowed ☐Separated
   ☐Divorced ☐Other (please specify) _____

7. List the dates of marriages and divorces including current:

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

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

9. If, yes, how long have you been in this relationship?_____

10. What factors made you decide to commit to this person?_____
_____

11. Describe your partner's personality_____
_____

12. How satisfied are you with your current relationship?_____
_____

13. Describe any problems or concerns that you have had_____
_____

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

15. 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 with him/her?*

16. Please list others whom you feel have an important impact on your life:_____

_____

17. Do any of the people in your life have problems that concern you? If so, please explain:

_____

_____

18. 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 yourself or in a close relative_____

_____

☐Other situations that have been traumatic_____

_____

19. What is your father's name? _____ Is he living? ☐ Yes ☐ No
What is his occupation? _____ How old is he?_____
How is his health? _____

20. What is your mother's name? _____ Is she living? ☐ Yes ☐ No
What is her occupation? _____ How old is she?_____
How is her health? _____

21. As a child how did your parents reward you?_____

22. As a child, how did they discipline you?_____

23. How many children were there in your family when you were growing up?_____
    a. How many were older than you?_____
    b. How many were younger than you?_____

24. If either of your parents died, please describe your reaction to this? _____

_____

25. If your parents are divorced, please indicate how old you were when they divorced and any describe your reaction:_____

_____

26. Whom do you feel you can talk to if you have a problem?_____

Developmental History

27. Did your mother take medication, use alcohol, drugs, or tobacco while pregnant?
    ☐ Yes ☐ No
    If yes, amount/day?_____

28. Complications with pregnancy included: (Check all that apply)

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

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

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

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

32. 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_____

33. What is the happiest memory of your childhood?_____

_____

34. What is the saddest memory of your childhood?_____

_____

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

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

_____

37. How did you learn about sex? _____

_____

38. Do you have any sexual concerns? If yes, please explain_____

_____

Medical History

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

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

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

	Age		Age
☐ Vision (wears glasses, etc.)	____	☐ Hearing (hearing aids, etc.)	____
☐ Chronic ear infections	____	☐ Coordination (running, throwing, writing)	____

If yes, please describe:_____

_____

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

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

Illnesses/Persistent Conditions	*Age of Onset*	*Treatment*

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

_____

_____

_____

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

Accidents/Falls – what happened	*Age at Time*	*Treatment and aftereffects*

44. Please list below any medications that you are currently taking.

Current Medications	*Dosage*	*Reason Prescribed*	*Side effects*

45. Date of last physical? _____
Name of your physician _____

Psychiatric History

46. Have you sought mental health treatment before? ☐ Yes ☐ No
If yes, please list the professional, reasons for treatment, and dates seen

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

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

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

48. 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 given occasion during the past month?_____

49. Do you currently smoke tobacco? ☐ Yes ☐ No
    a. If yes, are you thinking about quitting? ☐ Yes ☐ No
    b. Would you like assistance with quitting or cutting down? ☐ Yes ☐ No

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

Condition -- Indicate who (e.g. son, mother, brother, etc.)

☐ ADHD/ADD_____
☐ Alcohol Abuse_____
☐ Anorexia/Bulimia_____
☐ Anxiety/Nervousness_____
☐ Bipolar Disorder/Manic Depression_____
☐ Dementia_____
☐ Depression_____
☐ Drug Abuse_____
☐ Growth Problems_____
☐ Intellectual Disability_____
☐ Physical disability (blindness, hearing, loss of limb)_____
☐ Schizophrenia_____
☐ Seizures/convulsions/Epilepsy_____
☐ Sudden Death_____
☐ Suicide Attempt_____
☐ Other illness, please explain

Academic/Occupational History

51. What is the last grade of schooling that you completed?_____

52. What were your best subjects in school?_____
What were your worst subjects in school?_____

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

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

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

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

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

Legal History

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

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

Recreational/Personal History

60. How do you enjoy spending your time? _____
    _____

61. Please list the leisure activities that you most enjoy? _____
    _____

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

63. Please list any organizations, clubs, teams or groups with which you are involved (e.g. church, PTA, AA, NA, AL-ANON, Children's Division): _____
    _____
    _____

64. What do you see as your strengths? _____
    _____

65. What do you see as your weaknesses?

66. What benefits do you hope to derive from the services we provide?

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.