

ADULT DEVELOPMENTAL INVENTORY

NAME: _____

DATE: _____

AGE: _____ SEX: Male Female T or Q BIRTHDATE: _____

I. Pregnancy and Birth

- 1. Were there any illnesses during **your mother's** pregnancy with you? No ___ Yes ___
- 2. Was the pregnancy a full nine months? No ___ Yes ___
If not, how long? _____
- 3. How much did you weigh at birth? _____ lb. _____ oz.
- 4. Did you have any trouble starting to breathe or any trouble in the hospital? No ___ Yes ___
- 5. Did you remain in hospital after your mother went home? No ___ Yes ___

II. Development

Did you sit, walk, talk, and learn as quickly as other children in your family? No ___ Yes ___

III. Family--Social History

- 1. Are your parents in good health? No ___ Yes ___
- 2. Are there any other members of your immediate family (brothers, sisters, parents, grandparents, aunts, uncles) with a serious health problem (mental or physical)? No ___ Yes ___
- 3. Did you experience any significant losses or stressful events growing up?
If yes, please explain _____
- 4. Any significant stressful events and or losses in your life recently ? No ___ Yes ___
If yes, please explain _____
- 5. What is your identified cultural or ethnic background? _____
- 6. Do you consider yourself a spiritual or religious person? No ___ Yes ___
If yes, do you identify with a particular faith or denomination? _____

IV. Infections and Illnesses

- 1. Have you ever had
 - any trouble hearing or seeing? No ___ Yes ___
 - more than fifteen (15) absences from work last year? No ___ Yes ___
 - convulsion, fainting spell, or seizure? No ___ Yes ___
 - fever over 101 degrees? No ___ Yes ___
 - highest temperature? _____ how long? _____
 - major illnesses or diseases? No ___ Yes ___
Please list. _____
 - to stay in the hospital overnight? No ___ Yes ___
Why? _____

2. Have you taken any medication for an extended period of time? No ___ Yes ___
If so, please list medications and reasons for taking medications. _____

3. Any other health problems, which might influence your learning or activity; i.e., heart problems, diabetes, kidney problems, hyperactivity? Please explain. _____

V. Accidents

Have you ever had any serious injuries or accidents? No ___ Yes ___
Poisoning _____ Broken Bones _____ Loss of Consciousness _____
Head Injury _____ Car accident or other trauma _____

VI. Behavior

1. How well did you do in school? _____

2. Did you repeat any grade? No ___ Yes ___ Which grade? _____

3. Do you have any learning disabilities? No ___ Yes ___ What are they? _____

4. Are you worried about any work problems? No ___ Yes ___
If yes, please list. _____

5. Do you have any concerns about your social or family relationships? No ___ Yes ___
If yes, what are they? _____

6. Are you concerned about any of the following? (Circle which ones)

- | | | |
|------------------|--------------------------|---------------------------------|
| Anxiety or fears | Social avoidance | Self esteem issues |
| Overactivity | Irritability or anger | Depression |
| Worries | Impulse control problems | Poor concentration |
| Obsessions | Trouble with the law | Difficulty sustaining attention |
| Jealousy | Appetite problems | Trouble learning |
| Shyness | Weight gain or loss | Memory problems |
| Nail biting | Sleep problems | Substance abuse |

Please note the date of your last complete physical. _____

How often have you seen your doctor in past year? Give number of times. _____

Signature: _____ Date: _____