ASBELL
HEALTH STRATEGIES

ADULT DEVELOPMENTAL INVENTORY

NAME: _____ DATE: _____

AGE:_____ SEX: ☐ Male ☐ Female ☐ T or Q BIRTDATE:_____

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? _____

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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:_____