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YOUNG ADULT BACKGROUND HISTORY FORM

This questionnaire deals with the following: Prenatal development, medical history, performance in school, & family history. Please provide as much detail as possible. If you have additional information, such as school reports or previous assessments, please bring these along. All this information will be reviewed with you in detail, but it is helpful to have a complete & accurate record before we meet. Thank you!

Today's Date:___________________ **Name of Individual Completing Form:** ____________________
(If not patient)

Relationship to patient: ____________________

Patient's Demographic Information:

Name:	
Sex assigned at birth:	
Preferred pronouns:	
Age:	
Birthdate:	
School (if applicable):	
Grade (if applicable):	

Please check to indicate role:

	Biological	Step	Adoptive
Parent Name:			
Parent Name:			
Other Parent/Caregiver Name(s):			

If parents are separated or divorced, please specify date, age of child at that time, and explain the resulting custody arrangements:

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EVALUATION OBJECTIVES: CURRENT NEEDS

What are your goals & expectations for this evaluation? What do you want to discover?

1)

2)

3)

What are your strengths?

1)

2)

3)

Please list your current difficulties. Include when you first became concerned and what you think may be the cause of the problem.

1)

2)

3)

FAMILY HISTORY

There are two Home sections below. If you reside in one home, please complete only Home 1. If you rotatebetween homes, such as in a shared-custody situation, please complete both Home 1 and Home 2.

Please list all the people living in your **Home 1**:

Name	Age	Relationship to you

Please list all the people living in your **Home 2**:

Name	Age	Relationship to you

Please provide information about primary caregivers.

	Age	Level of Education	Occupation	Please describe any learning or attention difficulties
Parent 1:				
Parent 2:				
Other Parent/Caregiver:				
Other Parent/Caregiver:				

Please check for each sibling: Full or half-sibling, or not biologically related.

Sibling Name	Age	Level of Education	Full	Half	Not Blood	Please describe any learning or attention difficulties

Please check the relationship status that best suites you:

Not Dating	Casual Dating	Serious/Engaged/Living with a Significant Other	Married	Divorced (indicate number of previous marriages)

Please list your children's names and ages if applicable:

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MEDICAL HISTORY

Please list and describe any medical conditions that run in the family (including but not limited to thyroid disease, diabetes, elevated blood pressure, heart problems, and cancer). See the following table for learning and psychological/psychiatric conditions.

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Does any relative have:	**Yes**	**No**	**Relationship to Child (Specify blood relation or not)**	**Description of Issue**
Learning Problems (Be specific)				
ADHD				
Tourette's Syndrome or tics				
Autism Spectrum Disorder or Asperger's Syndrome				
Anxiety or Panic				
Obsessions/Compulsions				
Depression				
Bipolar Disorder				
Suicidal or Self- Injurious Behavior				
Schizophrenia				
Impulsive, Risk-Taking Behavior				
History of Victimization or Trauma				
Drug or Alcohol Abuse (Be Specific)				
Psychiatric Hospitalization				
Other emotional difficulties				
Genetic Disorder				
Neurological Condition (e.g., seizures, stroke, brain tumor)				

OBSTETRICAL HISTORY: PREGNANCY & BIRTH

If you can, please discuss these questions with an individual who has records of pregnancy.

Please answer the following:

Were you adopted? *If yes, at what age and from where?*	
Was it difficult to become pregnant and/or was medical intervention required? *If yes, please specify if possible.*	
Did the mother see a doctor for prenatal care? *If yes, please indicate month care began.*	
How many times was the mother pregnant prior to this pregnancy?	
Did she ever have any miscarriages or abortions? *If yes, please specify if possible.*	
During the pregnancy, how much weight did the mother gain (or lose)?	
Age of mother at delivery	
Age of father at delivery	

Did any of the following occur?	**Yes**	**No**	**If yes, please explain**
Amniocentesis			
Bleeding or Spotting			
Placental Abruption			
Kidney Trouble			
High Blood Pressure			
Swelling of Ankles			
Toxemia or Preeclampsia			
Low Salt Diet			
Water Pill (Diuretics)			
Sugar in Urine/Gestational Diabetes			
Rh Factor			
Mother receive Rhogam			
Sickle Cell			
Premature Labor			
Maternal Illness (Rashes, Fevers, Infections)			
X-Rays			
Accident			
Hospital Stay			
Cigarettes/Tobacco (frequency & quantity)			
Alcohol (frequency & quantity)			
Other Maternal Drug/Substance Use			
Emotional/Other Stress			

Please check next to medications used during pregnancy and add any other medications under "Other":

Birth control pills	Prenatal vitamins	Prenatal Calcium/Iron	Antibiotics
Medicine to keep baby/prevent labor	Sleeping pills	Tranquilizers	Reducing Pills
Anticonvulsants (for seizures)	Antidepressants	Steroids (prednisone)	Other:

Please answer the following:

How many hours was the mother in labor?	
Apgar Scores (at 1 and 5 minutes)	
Birth weight (pounds, ounces)	
Name of hospital in which you were born	
How many days after delivery did mother and baby leave the hospital?	
Was the pregnancy full-term? *If no, please indicate week of pregnancy child was born.*	
Did the mother go into labor by herself? *If no, was labor induced?*	
Was delivery by Caesarian Section? *If yes, what was the reason for the C-section?*	
Were you born headfirst? *If no, what occurred?*	

Did any of the following complications occur during delivery?	**Yes**	**No**
Forceps or Vacuum extraction used		
Premature rupture of membranes (water broke too early)		
Doctor had to "turn" the baby		
Multiple births (twins, triplets, etc.)		
Hemorrhage		
High Blood Pressure		
Other Complications (specify):		

Did any of the following complications occur after delivery?	**Yes**	**No**
Put in incubator		
Blueness		
Respiratory Issues (difficulty breathing)		
Jaundice (yellow skin)		
Convulsions		
Did not feed well		
Mother had Postpartum Depression		
Other difficulties (specify):		

Did any of the following difficulties occur as a newborn?	**Yes**	**No**
Colic, excessive irritability, inconsolable crying		
Did not sleep very much		
Stiff, arched back		
Too floppy		
Sleepy, lethargic – had to wake baby to feed		
Feeding problem		
Breathing problem		
Did not like to be held		
Failure to Thrive		

Any other obstetrical history concerns that have not been listed? If yes, please describe them:

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DEVELOPMENTAL HISTORY

As best as you or your parent/guardian can recall, what was the approximate age at which this preference was noticed? If you cannot recall the age, check the appropriate box to the right.

Milestone	Age	Early	Normal	Late
Sat without support				
Crawled				
Stood without support				
Walked without assistance				
Spoke first words (other than “mama” or “dada”)				
Said phrases (2-3 words)				
Said sentences				
Spoke clearly and fluently				
Potty trained through the day				
Potty trained through the night				
Rode a tricycle				
Rode a bicycle				
Got dressed alone				
Buttoned own clothing				
Tied shoelaces				
Named colors				
Named letters and/or numbers				

Please answer the following:

Which hand do you prefer to use?	
What was the approximate age at which you/your caregiver noticed this preference?	
Have you ever been more active, restless, or fidgety than others? *If yes, when did you first notice this?*	
Do you seem more impulsive, fearless or prone to risk-taking compared to peers? *If yes, when did you first notice this?*	
Do you seem easily distracted and have trouble attending to chores or schoolwork? *If yes, when did you first notice this?*	
Were you ever told you were hyperactive or had ADD/ADHD? *If yes, please describe.*	

Currently, how well do you function in the following areas when compared to peers?

Skill	Much worse	Worse	Similar	Better	Far better
Walking					
Running					
Athletics					
Handwriting					
Language/Communication					
Following directions					

SENSORY HISTORY

Have you displayed the following behaviors, particularly during childhood?

Behavior	Yes	No	Sometimes (If so, when?)
Avoids certain textures (sand, mud, foods, lotions, etc.)			
Strongly dislikes having hair washed, combed or brushed			
Strongly dislikes having dirty hands			
Trouble tolerating touching, hugging, or cuddling			
Prefers to wear only certain types of clothes			
Frequently walks on tiptoes			
Overly sensitive to sounds (put hands over ears)			
Becomes easily distracted by environmental sounds			
Frequently chews on clothes or objects			
Avoids eating certain types of textures or foods			
Overly sensitive to smells			
Avoids swinging, sliding, or using playground equipment			
Seeks out swinging			

Have you ever had any of the following problems?	Yes	No	Sometimes (If so, when?)
Poor balance			
Poor motor coordination			
Uses too much or too little pressure with objects			
Avoids using vision to coordinate hand/body movements			
Difficulty with puzzles, colors, and shapes			
Blinks excessively when trying to catch balls or balloons			

Have you ever exhibited any of the following behaviors?	Yes	No
Head-banging		
Hair-twirling		
Hair plucking, pulling or skin-picking		
Hand-flapping		
Twirling		
Twitches or excessive eye blinks		
Throat clearing		
Excessive worries or fears		
Worries about dirt or germs		
Needs to carry out certain rituals		
Feels you have to be perfect		
Likes things to be very neat and clean		
Argues a lot		
Does not carry out requests		
Sad, unhappy, depressed		
Irritable		
Hits other people		
Frequent temper tantrums		

Any other sensory, motor or movement concerns that have not been listed? If yes, please describe them:

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SOCIAL HISTORY

Please answer the following:	Yes	No	If yes, please describe:
Have you ever had trouble starting or stopping an activity?			
Have you ever had difficulty interpreting or using eye contact, facial expressions, or gestures?			
Have you ever had trouble participating in back-and-forth conversation?			
Do you enjoy socializing with others currently?			
Have you ever had trouble developing and/or maintaining friendships?			
Have you ever had trouble with changes in activities or routines?			
Have you ever harmed an animal or another person?			
Have you ever had a specific interest in fire, especially starting fires?			
How many close friends do you have (Please specify ifdifferent during childhood)?			
Have you had any trouble developing romantic or intimate relationships, if you have been interested?			

ACADEMIC/SCHOOL HISTORY

Last grade completed: ___________

Please list all the schools you have attended (including elementary, middle, high schools, and any colleges/universities attended). Please also indicate if school is an alternative education facility.

School Name & Location	**Grades/Dates Attended**	**Classroom Type** (e.g., special education, regular classroom, gifted)	**Supports provided** (e.g., classroom aide, speech therapy)

If enrolled in school please list all current academic classes and grades:

Class Name	Grade (e.g., A, B, C, D, F; S/U; I)

Please answer the following:	Yes	No	Explanation
Have you ever repeated/skipped or accelerated through a grade? *If yes, which grade(s) and what was the reason?*			
Have you ever failed a course? *If yes, please explain.*			
Do you get along with classmates? *If no, please explain.*			
Have you ever been provided with an Individualized Education Program and/or Section504 Accommodation Plan? *If yes, please provide categorization, grade when established, and grade when it ended (if applicable).*			
Have you ever been told you have a learning disability? *If yes, please explain.*			
Previously or currently been enrolled in an advanced or gifted curriculum? *If yes, please list subjects.*			
Have you taken the SAT/ACT? *If yes, please list your scores.*			
Do/did you get along with teachers? *If no, please explain.*			

Please answer the following:

What is/was your best and/or favorite subject in school?	
What is/was hardest for you in school?	
Do you get along with classmates?	
How do you get along with teacher(s)?	
How many hours per night do/did you spend on homework?	

Please answer the following:	**Yes**	**No**	**Explanation**
Is/was getting homework done stressful for you or your family? *If yes, please explain*			
Do you feel the school is/was dealing with your problems appropriately? *If no, please explain.*			
Please describe your contact re: your problems with school staff: (ex. administrators, teachers, tutors)			
Do you feel the school is/was helping you use your strengths appropriately? *Please explain.*			

Please describe your ability to handle homework (Check your answer):

Homework Task	**Don't Know**	**Needs Constant Supervision**	**Partially Independent**	**Almost Independent**	**Completely Independent**
You can/could keep track of your own assignments.					
You complete/completed assignments, and on time.					
You plan/planned and complete/completed long-term projects and papers.					

Please comment on any of the above statements or any other concerns you may have regarding school:

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PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Have you ever seen:	**Yes**	**No**	**Name(s)**	**Dates**
A psychiatrist (MD)?				
A psychologist (PhD or PsyD)?				
A therapist (LPC, MSW, LMFT, etc.)?				
A speech/language therapist?				
An occupational or physical therapist?				
A tutor or other academic support/coach?				
A neurologist (MD)?				

Please answer the following:	Yes	No	Description
Have you previously or currently exhibited low mood for extended periods of time (several days or weeks)? *If yes, please describe.*			
Have you previously or currently expressed hopelessness or thoughts of harming themself or another? *If yes, please describe.*			
Have you ever exhibited frequent worries or other signs of anxiety?			
Have you ever been hospitalized for psychiatric reasons? *If yes, please describe the circumstances and give the dates of hospitalization.*			
Are you concerned about your use of alcohol or drugs? *If yes, please explain your concerns.*			
Are you concerned that you might have been abused or traumatized? *If, yes, please explain your concerns.*			
Have you ever had educational or neuropsychological testing done before? *If yes, please list the evaluator, the date(s) testing was done & the tests taken.*			
Other prior evaluations? *If yes, please list evaluation type, name of evaluator, & testing date(s).*			

MEDICAL HISTORY

Have you ever experienced any of the following health concerns?

Please describe your nighttime habits:	
Do not like to go to bed	
Can't fall asleep	
Wake up in the middle of the night	
Wander around in the middle of the night	
Afraid of the dark	
Nightmares	
Wake up too early in the morning	
Very hard to wake up	
Snore	
Have pauses or interruptions in breathing while sleeping	
Bedwetting	
Fall asleep or get drowsy during the day	
Sleepwalking	
Repetitive dreams	
Limbs jerking	

Medical Concern	**Yes**	**No**	**Describe**
Vision Problems			
Hearing Problems			
Ear Infections			
Allergies or sensitivities			
Headaches (if migraines please specify)			
Stomach Aches			
Strep Throat			
Heart, lung, kidney, or other organ problems			
Diabetes			
Endocrine (e.g. Thyroid, growth problem, etc.)			
Concussion			
Moderate or Severe brain injury			
Seizure			
Dysautonomia (POTS)			
Hypermobility Syndromes (e.g. Connective Tissue Disorders, Ehler's Danlos Syndrome)			
Nicotine Use			
Sexual concerns			

Have you ever had any hospitalizations or operations? If yes, please list below.

Date	**Hospital Name, City and State**	**Reason for Hospitalization**

Please answer the following questions:	**Yes**	**No**	**Describe**
Do you have a good appetite? *If no, please explain.*			
Do you require a special diet? *If yes, please explain.*			
Do you get enough exercise? *Please describe the kind and amount.*			
How many hours of sleep do you get each weeknight?			
How many hours of sleep do you get each night on weekends/holidays?			
Have you used alcohol?			
Have you used drugs?			

Please list any medications, supplements, and or homeopathic remedies you are currently taking:

Name of Medication	Strength	When Started	How many times per day

Please list any medications you have taken in the *past*, except for antibiotics and decongestants:

Name of Medication	Reason Prescribed	Strength	When Started	Effect (Positive/Negative)

Please list any recreational substances you are currently using or have used:

Substance	Frequency	Quantity	How recently
Alcohol			
Marijuana			
Psychedelics			
Amphetamines (e.g., Cocaine, etc.)			
Opioids			
Other			

Please check here if you prefer to discuss at intake rather than indicate in writing.

EMPLOYMENT HISTORY

Please answer the following questions:

What is your current occupation? *Please specify Part-Time or Full-Time.*	
Are you a student? *Please specify Part-Time or Full-Time.*	
Are you currently unemployed? *Please specify how long you have been unemployed and the reason(s).*	
What is your present job title?	
Who is your current employer?	
How long have you worked there?	
How many hours do you work each week?	
What are some difficulties you have had in performing your current or past job?	

LEGAL HISTORY

Please answer the following questions.	**Yes**	**No**	**Please describe**
Are you currently involved in any litigation?			
Have you ever been arrested?			

DRIVING HISTORY

Please answer the following questions.	**Yes**	**No**	**Please describe**
Do you currently have a driver's license?			
Has your driver's license ever been taken away?			
Have you ever been in an accident when you were driving?			
Do you like to drive fast?			
Do you find it hard to wait at red lights?			
Have you ever been stopped by the police for speeding? *If yes, indicate number of times.*			
Have you ever been arrested for driving under the influence? (DUI)			

PROFESSIONALS CURRENTLY PROVIDING CARE

Please note: To assure confidentiality, contact will not be made without a completed Authorization to Release/Request Information signed by the patient.

Name	Care Provided	Telephone Number	Fax Number	E-mail Address

Please provide any other pertinent information that was not adequately addressed in this form (continue on the back if needed):