

## 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: \_\_\_\_\_