**Developmental and Medical History Form**

**Please complete the following information about you. The more accurate and up to date the information provided, the better we can serve you. This form is designed to be completed on your computer.**

 **Today’s Date**:

**Your Legal Name:**

**Your Nickname/Chosen Name:**

**Date of Birth:**

**Age:**

**Gender:**

**Race:**

**Relationship Status:**

**Children? Yes No**

**If yes, ages of your children**

**Who referred you here?**

**What is the primary reason you are seeking services?**

**Who should we contact in case of an emergency?**

**Name contact number relationship**

**Name contact number relationship**

**Where do you live?**

**Address: town zip code**

**Who else lives in your home?**

**Where do you work**

**Work contact information:**

**FAMILY History**

**Any complications with your birth?**

**Any difficulties learning in school?**

**What is the highest level of education you have completed?**

**Do you have any siblings?**

**What type of relationships do you have with members of your immediate family?**

**Have you experienced any traumatic events (child abuse, interpersonal violence, medical interventions)? Yes No**

**If yes, please note type of traumatic event and age you experienced it.**

**Has anyone in your family ever had difficulties with emotional, behavioral, or family problems (depression, anxiety, ADHD, bipolar, high conflict, abuse etc.)?** Yes No I don’t know

**If yes, describe the problems:**

**Have you ever received treatment for emotional, behavioral or family problems (depression, anxiety, ADHD, bipolar, high conflict, abuse etc)?** Yes No

**If yes, for what type of problem?**

**Who provided the treatment and when?**

**Was treatment helpful?** Yes No

**Have you ever experienced or received help with alcohol or drug problems?**

 Yes No

 **If yes please explain:**

**Has anyone in your family ever experienced or received help with alcohol or drug problems?**  Yes NoI don’t know

**If yes, who and what kind of problems?**

**Are you involved with other services/agencies?** Yes No

**If yes, which agencies and for what services?**

**Strengths:** *Choose all that apply*

 **good sense of humor make friends easily funny creative artistic intelligent kind easy going have friends share feelings stand up for beliefs finish projects hopeful/positive figures things out believe in self gentle with small children/animals**

 **dedicated hard working tolerant of differences brave considerate ask for help if needed enjoy people enjoy physical activity stand up for self comfort others in need able to comfort self helpful take care of self build/design things others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY**

**Primary Care Clinic:**

**Physician Name:**

**Are you currently on any medications?** Yes No

**If yes, complete the chart below.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Clinic/Physician Name** | **Clinic Phone #** |
| 1)  |  |  |  |
| 2)  |  |  |  |
| 3)  |  |  |  |
| 4)  |  |  |  |

**Health Issues:**

**Allergies** YES NO If yes, explain

**Diabetes** YES NO If yes, explain

**Headaches** YES NO If yes, explain

**Head Injury** YES NO If yes, explain

**Seizures** YES NO If yes, explain

**Respiratory Illness** YES NO If yes, explain

**Hearing Problems** YES NO If yes, explain

**Eye Problems** YES NO If yes, explain

**Vision Problems** YES NO If yes, explain

**Stomach Problems** YES NO If yes, explain

**Eating Disorders/Weight Problems** YES NO If yes, explain

**Chronic Illness or Disabilities** YES NO

 If yes, explain

**Self Injury** YES NO

 If yes, explain

**Medical Hospitalizations** YES NO

 If yes, explain

**Psychiatric Hospitalizations** YES NO

If yes, explain

**Other Health Issue(s)**

**Date of Last Tetanus Shot**

**Use of the following:**

**Alcohol** YES NO

If yes, amount

**Street Drugs** YES NO

If yes, amount

**Diet Pills**  YES NO

If yes, amount

**Is there any other information you feel is important for us to know that we have not asked about? If yes, provide information here.**

***I have provided complete and accurate information about myself to the best of my ability. I know of no reason why I cannot be assessed and/or treated at Rebecca J Hubbard PLLC.***

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**Client Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinician Date**