# WINS*i*

**WESTERN INSTITUTE FOR NEURODEVELOPMENTAL STUDIES AND INTERVENTIONS**
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## ADULT

## DEVELOPMENTAL NEUROBEHAVIORAL DATABASE

Name: _____ Today's Date: _____

Birth Date: _____

Age: _____

Name of Individual Filling Out Questionnaire (*if not patient*): _____

Relationship to Patient: _____

INSTRUCTIONS:

*The following questions deal with your reasons for seeking assistance, your mother's pregnancy with you, your developmental and medical history, your academic performance, and your family history, in addition to other details.*

*Please complete this questionnaire with as much detail as possible. Feel free to make notes and provide as much additional information as is needed. You may use the back of these sheets or additional documents if you run out of space.*

*If you have any school reports or previous assessments, bring these to your scheduled appointment. All of this information will be reviewed with you in detail, but it is helpful to have a complete and accurate record to start with. Thank you!*

**CONTACT FORM**

Name: _____

Address: _____

_____

Telephone: Home: _____ Cell: _____ Work: _____

Fax: _____ Email: _____

Primary contact (*circle one*): Home Phone – Cell Phone – Work Phone – Email

Secondary contact (*circle one*): Home Phone – Cell Phone – Work Phone – Email

**EMERGENCY CONTACT INFORMATION**

Name: _____

Relationship: _____

Address: _____

_____

Telephone: Home: _____ Cell: _____ Work: _____

Fax: _____ Email: _____

Primary contact (*circle one*): Home Phone – Cell Phone – Work Phone – Email

Secondary contact (*circle one*): Home Phone – Cell Phone – Work Phone – Email

**CURRENT CONCERNS**

What are your expectations from this evaluation? What do you want to discover?

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

*a)*

*b)*

*c)*

*d)*

*e)*

*f)*

**OBSTETRICAL HISTORY** *(If possible, please discuss these details with your mother.)*

How old was your mother when pregnant with you?

How many times was your mother pregnant prior to this pregnancy?

Were there ever any miscarriages or abortions?
*If yes, please indicate year and month of pregnancy:*

Did your mother see a doctor for prenatal care?
*If yes, please indicate which month of pregnancy care began:*

During the pregnancy, how much weight did your mother gain? If weight loss occurred, how much was lost?

Please list the name of the hospital in which you were born: _____

During this pregnancy, 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 | | | |
| Rh Factor | | | |
| Mother receive Rhogam | | | |
| Sickle Cell | | | |
| Premature labor | | | |
| Maternal illness (rashes, fevers, infections) | | | |
| X-Rays | | | |
| Accident | | | |
| Hospital stay | | | |
| Cigarettes | | | |
| Alcohol | | | |
| Maternal drug use | | | |
| Emotional/other stress | | | |

Were any of the following medications taken during the pregnancy?

| | Yes | No |
|---|---|---|
| Birth control pills | | |
| Prenatal vitamins | | |
| Prenatal Calcium/Iron | | |
| Medicine to keep baby (prevent labor) | | |
| Antibiotics | | |
| Anticonvulsants (for seizures) | | |
| Steroids (prednisone) | | |
| Sleeping pills | | |
| Antidepressants | | |
| Tranquilizers | | |
| Reducing pills | | |

Were any other medications taken during pregnancy?

*If yes, please list them:*

Was this a full term (9 month, 38 to 42 week) pregnancy?

*If no, please indicate what week of pregnancy you were born:*

Did your mother go into labor by herself?

*If no, was the labor induced?*

Was delivery by Caesarian Section?

*If yes, what was the reason for the C-section?*

How many hours was your mother in labor?

Were you born head first?

*If not, what occurred?*

Were forceps used?

Was vacuum extraction used?

Apgar Scores: _____

Were there any other complications of delivery?

| | Yes | No |
|---|---|---|
| Premature rupture of membranes (water broke too early) | | |
| Doctor had to "turn" the baby | | |
| Twins or triplets | | |
| Hemorrhage | | |
| High blood pressure | | |
| Mother had Postpartum Depression | | |

Were there any other complications?

*If yes, please describe them:*

Did the baby have any of these problems after delivery?

| | Yes | No |
|---|---|---|
| Put in an incubator | | |
| Blueness or trouble breathing | | |
| Jaundice (yellow skin) | | |
| Convulsions | | |
| Did not feed well | | |

Were there any other difficulties after delivery?

*If yes, please describe them:*

What was your birth weight?

When did mother and baby leave the hospital?

**DEVELOPMENTAL HISTORY** *(If possible, please discuss with the person(s) who raised you.)*

As a newborn, did you have any of the following difficulties?

| | Yes | No |
|---|---|---|
| Colic, excessive irritability, inconsolable crying | | |
| Did not sleep very much | | |
| Too 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 | | |

Did any other difficulties occur that were not listed above?
*If yes, please describe them:*

When were you able to sit alone, WITHOUT propping or help?

When did you start to walk WITHOUT holding on to something?

When did you start to babble (bababa….gagaga)?

When did you first speak words with meaning?

When did you say short sentences, such as "I want milk" or "go bye bye"?

By age 2, was your speech clear to other people?
*If not, please explain:*

Did you have trouble learning to speak?
*If yes, please explain:*

Were you able to follow simple instructions?
*If not, please explain:*

Did you have any difficulty chewing or swallowing food?
*If yes, please explain:*

At what age was toilet training accomplished?

Did you have difficulty with soiling or wetting after being toilet trained?
*If yes, please explain:*

When did you learn to ride a tricycle?

When did you learn to ride a bicycle without training wheels?

When were you able to get dressed alone?

When did you learn to tie shoelaces?

What hand do you prefer to use?

*At what age did you notice this preference (circle one)?*

*Before 1 year old* *After 2 years old* *After 4 years old*

Please circle ***Yes*** or ***No*** in the following questions and explain if necessary:

Are you more active, restless, or fidgety than others your age? ***Yes*** ***No***
*If yes, when did you first notice this*?

Do you have trouble controlling impulses? ***Yes*** ***No***
*If yes, when did you first notice this?*

Do you seem to be easily distracted and have trouble attending to chores, school, work, work or TV? ***Yes*** ***No***
*If yes, when did this start?*

Were you ever told you were hyperactive or had ADD/ADHD? ***Yes*** ***No***
*If yes, please explain.*

## MEDICAL HISTORY

Have you ever had any serious medical illness?

*If yes, please describe:*

Have you ever had any hospitalizations or operations?

*If yes, please complete the following table:*

| Date | Hospital Name, City and State | Reason for Hospitalization |
|---|---|---|
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Have you ever had any of the following health problems?

| | Yes | No | If yes, please explain: |
|---|---|---|---|
| Poor vision/Eye problems | | | |
| Repeated ear infections | | | |
| Hearing loss | | | |
| Sinus infections | | | |
| Throat infections | | | |
| Heart (murmur, irregular heartbeat, high blood pressure) | | | |
| Pulmonary problems (bronchiolitis, pneumonia, asthma) | | | |
| Chronic constipation or diarrhea | | | |
| Stomach aches/upset, nausea, vomiting, indigestion | | | |
| Kidney, bladder or urinary issues | | | |
| Muscle, bone, joint issues | | | |
| Fractures | | | |
| Skin or hair issues | | | |
| Headaches or migraine headaches | | | |
| Seizures | | | |
| Head injury, concussion | | | |
| Loss of consciousness | | | |
| Endocrine (thyroid, etc.) | | | |
| Anemia, low white count | | | |
| Allergies | | | |
| Weight issue | | | |
| Poisoning | | | |
| Accidents | | | |
| Serious injury | | | |
| Back pain | | | |
| Genetic conditions diagnosed by genetic testing | | | |
| Tobacco use | | | |

Have you ever had any other health problems not listed above?
*If yes, please describe:*

Have you had any sporting or motor vehicle accidents?
*If yes, please describe:*

Do you have a good appetite?
*If no, please explain:*

Do you require any sort of special diet?
*If yes, please describe it below:*

Do you get enough exercise?
*If yes, please describe it below:*

How many of hours of sleep a night do you get?

Are week nights the same as weekends and holidays?
*If not, please list how much sleep is had on these nights:*

Please indicate if you have experienced any of the following nighttime habits:

| | **Yes** | **No** |
|---|---|---|
| Does not like to go to bed | | |
| Can't fall asleep | | |
| Wakes up in the middle of the night | | |
| Wanders around in the middle of the night | | |
| Afraid of the dark | | |
| Nightmares | | |
| Wakes up too early in the morning | | |
| Very hard to wake up | | |
| Snores | | |
| Has pauses or interruptions in breathing while sleeping | | |
| Bedwetting | | |
| Falls asleep or gets drowsy in school | | |
| Sleepwalking | | |
| Repetitive dreams | | |

Please note any additional details:

Please list any medications that you are **currently** taking. Please include vitamins, over the counter medications and herbal remedies:

| Name of Medication | Strength | When Started | How Many Times a Day |
|---|---|---|---|
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Please list any medications you have taken in **the past**, *except* for antibiotics and decongestants:

| Name of Medication | Reason Prescribed | Strength | When Started | Child's Response |
|---|---|---|---|---|
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Are there any other concerns that have not been listed?

*If yes, please describe:*

**FAMILY HISTORY**

**Biological Father's Name:** _____

Age: _____ Level of Education: _____ Occupation: _____

Please describe any learning difficulties: _____

_____

**Biological Mother's Name:** _____

Age: _____ Level of Education: _____ Occupation: _____

Please describe any learning difficulties: _____

_____

**Siblings:**

Name: _____ Age: _____ Grade in School: _____

Relationship *(circle one)*: *Brother* *Sister*

Please describe any learning difficulties: _____

_____

Name: _____ Age: _____ Grade in School: _____

Relationship *(circle one)*: *Brother* *Sister*

Please describe any learning difficulties: _____

_____

Name: _____ Age: _____ Grade in School: _____

Relationship *(circle one)*: *Brother* *Sister*

Please describe any learning difficulties: _____

_____

Name: _____ Age: _____ Grade in School: _____

Relationship *(circle one)*: *Brother* *Sister*

Please describe any learning difficulties: _____

_____

Please list and describe any medical conditions that run in the family, including thyroid disease, diabetes, elevated blood pressure, heart problems, and cancer:

Does any blood relative have any of the following issues?

| | Yes | No | Relationship to Child (i.e. Maternal Grandmother) | Description of Issue |
|---|---|---|---|---|
| Anxiety | | | | |
| Obsessions/compulsions | | | | |
| Panic | | | | |
| Depression | | | | |
| Bipolar Disorder | | | | |
| Schizophrenia | | | | |
| ADHD | | | | |
| Impulsive, risk-taking behavior | | | | |
| History of victimization or trauma | | | | |
| Drug or alcohol abuse | | | | |
| Suicidal behavior | | | | |
| Tourette's Syndrome | | | | |
| Psychiatric hospitalization | | | | |
| Emotional difficulties | | | | |
| Learning problems | | | | |

Please list and describe any other psychiatric disorders possibly present in your family below. You may also use this space to elaborate on any issue listed above, such as emotional difficulties, learning problems, or attention deficit disorder. Please include specific information that relates the individual to the disorder:

## SOCIAL HISTORY

Please complete the following chart with the applicable names for the following individuals:

| | Biological | Step | Adoptive |
|---|---|---|---|
| Father | | | |
| Mother | | | |

If applicable, please list the names and ages of your children and their relationship to you (biological, adopted, or step):

| Name | Age | Relationship |
|---|---|---|
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Marital status:

- ☐ Married
- ☐ Separated
- ☐ Divorced
  - Number of previous marriages/divorces: _____
- ☐ Living with significant other
- ☐ Engaged or "serious"

Please list all the people living in your home:

| Name | Age | Relationship |
|---|---|---|
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What things do you enjoy doing?

What things do you do well?

How do you get along with others?

## SENSORY HISTORY

Have you ever experienced any of the following behaviors?

| | 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 | | | |
| Has trouble tolerating touching, hugging or cuddling | | | |
| Strongly dislikes having hair or fingernails cut | | | |
| Prefers to wear only certain types of clothes | | | |
| Frequently runs into or accidentally bumps objects or people | | | |
| Seems unaware of cuts, bumps or bruises | | | |
| Frequently walks on tiptoes | | | |
| Crawled with arched or fisted hands | | | |
| Over sensitive to sound (puts hands over ears) | | | |
| Becomes easily distracted by environmental sounds | | | |
| Has difficulty following directions | | | |
| Frequently chews on clothes or objects | | | |
| Avoids eating certain types of textures or foods | | | |
| Seems overly sensitive to smells | | | |
| Seems unaware of smells and tastes | | | |
| Craves tangy or zesty food | | | |
| Get carsick frequently | | | |
| Avoid swinging, sliding or using playground equipment | | | |
| Seek out swinging | | | |
| Avoid trampolines | | | |
| Hold hands or body in unusual positions | | | |

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 | | | |
| Has difficulty with puzzles, colors and shapes | | | |
| Blinks excessively when trying to catch balls or balloons | | | |

Please describe any other sensory concerns that have not been listed:

**PAST PSYCHIATRIC HISTORY**

Have you ever seen a psychiatrist?
*If yes, please list him/her and provide the dates seen:*

Have you ever seen a psychologist?
*If yes, please list him/her and provide the dates seen:*

Have you ever seen a therapist?
*If yes, please list him/her and provide the dates seen:*

Have you ever seen a speech/ language therapist?
*If yes, please list him/her and provide the dates seen:*

Have you ever seen an occupational therapist?
*If yes, please list him/her and provide the dates seen:*

Have you ever seen a neurologist?
*If yes, please list him/her and provide the dates seen:*

Have you ever seen a neuropsychologist?
*If yes, please list him/her and provide the dates seen:*

Have you ever been hospitalized for psychiatric reasons?

*If yes, please describe the circumstances and provide the dates of hospitalization:*

Have you ever had psychological testing?

*If yes, please list the evaluator, the dates testing was done, and the tests taken:*

Are you using alcohol?

*If yes, please explain:*

Are you using drugs?

*If yes, please explain.*

Have you been abused or traumatized?

*If yes, please explain.*

**If you have been on medications for psychiatric reasons, please include these on the medication lists in the past medical history.**

**EDUCATIONAL HISTORY**

Please indicate the last grade you completed:

Please list all the schools that you have attended in the following chart:

| | School Name | Location | Dates Attended | GPA |
|---|---|---|---|---|
| Elementary School | | | | |
| Middle School | | | | |
| High School | | | | |
| College/ University BA/BS | | | | |
| College/ University MA/MS | | | | |
| College/ University PhD | | | | |

If known, please indicate SAT scores:

*Math:* _____

*Critical Reading:* _____

*Writing:* _____

Have you ever repeated or skipped a grade?

*If yes, which grade and what was the reason?*

Have you ever been in a special tutoring class?

*If yes, what kind of class and what was the reason?*

Please mark ***Yes*** or N***o*** for the following questions:

| | **Yes** | **No** |
|---|---|---|
| Did you ever have difficulty learning to read? | | |
| Do you currently have difficulty reading? | | |
| Do you read slowly? | | |
| Do you have problems understanding what you read? | | |
| Did you ever have any problems with spelling? | | |
| Do you rely on a spell checker to produce an adequate document? | | |
| Did you have difficulty writing book reports and term papers? | | |
| Is the conceptual act of writing difficult for you? | | |
| Is the mechanical act of writing difficult for you? | | |
| Do you read the Daily newspaper? | | |
| Do you read the Sunday newspaper? | | |
| Do you read magazines (number per month: _____)? | | |
| Do you read technical/professional material? | | |
| If you took a foreign language class, was this a difficult learning experience? | | |
| Did you ever have any problems learning math? | | |

Please describe any details regarding the above questions:

Have you been in any gifted or honors classes?
*If yes, please describe:*

Have you ever failed a course?
*If yes, please describe:*

Have you ever been told you have a learning disability?
*If yes, please explain:*

What was/is your best subject in school?

What subject is hardest for you?

**EMPLOYMENT HISTORY**

Current Occupation:

- ☐ Student
- ☐ Full time (40 hr/week) employment
- ☐ Part time (20 hr/week) employment
- ☐ Unemployed

Current Employer: _____

Job Title: _____

Date of employment: _____

Number of hours worked each week: _____

If unemployed, how long have you been unemployed? _____

Reason for unemployment: _____

Please list any difficulties with your job: _____

_____

_____

_____

Please list any previous jobs:

| Employer | Position/ Title | Dates Employed | Reason for Leaving |
|---|---|---|---|
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## LEGAL HISTORY

Are you involved in any litigation?
*If yes, please explain:*

Have you ever been arrested?
*If yes, please explain.*

## DRIVING HISTORY

Please mark ***Yes*** or ***No*** for the following questions:

| | **Yes** | **No** |
|---|---|---|
| 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? | | |
| Have you ever been stopped by the police for speeding? # of times: _____ | | |
| Have you ever been arrested for driving under the influence (DUI)? | | |
| Do you find it hard to wait at red lights? | | |

Please explain any details regarding the above questions:

**PROFESSIONALS CURRENTLY PROVIDING CARE**

Please list any professional currently involved in your care along with their contact information. Please note, in order to assure confidentiality, contact will not be made without an *Authorization for Release of Information* signed by the patient or guardian.

| Name | Care provided | Telephone Number | Fax Number | Email Address |
|---|---|---|---|---|
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