ADULT DEVELOPMENTAL INVENTORY

CLIENT NAME:_____ DATE:_____

AGE: _____ SEX: _____ BIRTHDATE: _____

Please answer the following questions to the best of your ability. If you don't know the answers for sections I & II, answer the questions you DO know and mark the others with DK for don't know.

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? No___Yes___
5. Did you have any trouble in the hospital? No___Yes___
6. Did you remain in hospital after your mother went home? No___Yes___
7. How long did you stay in the hospital? _____days

II. Development

1. Did you sit alone before seven months of age? No___Yes___
2. Did you walk alone before 15 months of age? No___Yes___
3. Did you say any words by one and one-half years of age? No___Yes___
4. Were you as quick in learning as other children in the family? No___Yes___

III. Accidents

1. Have you ever had any serious accidents? No___Yes___
   Burns_____ Poisoning_____Broken Bones_____ Concussion_____
   Cuts needing a doctor_____ Automobile Accidents_____
   Other trauma _____

IV. Family--Social History

1. Are your parents in good health? No___Yes___
   If deceased, date and cause? _____

   _____

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___
   List each problem and who has it:_____

   _____

3. Does anyone help take care of you on a regular basis? No___Yes___

V. Medical issues and other problems

Have you ever:

1. Had more than fifteen (15) absences from work last year? No___ Yes___
   Reason? _____
2. Ever had convulsion, fainting spell, or seizure? No___ Yes___
3. Had to stay in the hospital overnight? No___ Yes___
   Why? _____

VI. Behavior

1. How well did you do in school? _____
   _____
2. Are you worried about any work problems? No___ Yes___ If yes, please list. _____
   _____
3. Did you repeat any grade? No___ Yes___ Which grade? _____
4. Do you have any learning disabilities? No___ Yes___ What are they? _____
   _____
5. Are you concerned about any of the following? (Circle which ones)

Bad temper	Overactive
Nail biting	Nightmares
Trouble learning new information	Irritable
Difficulty sustaining attention	Discipline Problem
Constipation	Weight gain/loss
Self Esteem	Depression
Poor Concentration	Worries
Appetite problem	Very shy
Jealousy	Sleep problems
Speech problems	Diarrhea

Signature: _____

Comments: _____