

Name: _____

Ψ Lifetime Development Adult Intake Medical History

D.O.B. _____

Today's Date _____

Diagnosis at Intake:

by: _____

Current Medications (incl. dosage)

Past Medications

Past Diagnostic Tests

(chromosomes, MRI, EEG, x-ray, allergies, etc. please give approx. dates or provide copies of testing reports)

REFERRAL SOURCE

(contact info): _____

(city) _____

(phone) _____

Health goals related to consultation with Lifetime Development:

Family History:

Father's Health: (kindly review Pages 3 & 4 of this form for any past & current health or mental health issues)

Past: _____

Current: _____

Substance abuse (describe):

Mother's Health: (kindly review Pages 3 & 4 of this form for any past & current health or mental health issues of mother)

Past: _____

Current: _____

Substance abuse (describe):

Mother's Pregnancy Information

(if known):

- Thyroid problem
 - Autoimmunity
 - Food supplements or medications taken during pregnancy
 - Vaccinations during pregnancy
 - Medications during pregnancy
- _____

Unhealthful practices such as smoking or drug or alcohol

Accidents, illness, traumatic events, or unusual stress during mother's pregnancy (please describe)

Infancy & Early Childhood

- Breastfed
- Formula
- Goat's Milk
- Early food intolerance
- Birth or Perinatal Stress:

- Speech or Motor delay in early childhood
- Other relevant early childhood information (e.g., high fever)

Neurological

- Handedness R L Ambi
- Headaches
- Migraines
- Dizziness
- Daytime drowsiness
- Weakness in muscles
- Unexplained loss of sensation
- Muscle spasms or tremors
- "Tics" (describe) _____

- Convulsions/fits/seizures
- Difficulties with distance, height, orientation in space

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General Health:

- Generally tired or worn out
- Abnormal sensitivity to cold/heat
- Lowered resistance to infection
- Immune deficiency
- Hot & cold spells (incl. hot flashes)
- Cold sweats during
- Excessive daytime perspiration
- Excessive nighttime sweating
- Flu-like or vague sick feelings
- Excessive thirst
- Allergies
- Excessive touch sensitivity
- Other: _____

Please rate the following behaviors for yourself on a scale from 1 to 10, where 1 = excellent or no problem & 10 = worst/greatest difficulty experienced.

Cognitive & Emotional

- Patience, self restraint _____
- Life and social judgment _____
- Drive, compulsiveness _____
- High activity level _____
- Low activity level _____
- Fidgetiness _____
- Moodiness _____
- Stress/tension _____
- Worry _____
- Anxiety/performance anxiety _____
- Fear, panic _____
- Difficulty with authority _____
- Irritability, quick anger _____
- Rages, tantrums _____
- Defensiveness _____
- Aggression _____
- Frustration tolerance _____
- Guilt/shame/sense of doom _____
- Tendency to cry _____
- Nail biting _____
- Addictive tendency _____
- Obsessiveness _____

Overuse of substances _____ (specify):

Tobacco _____

Caffeine _____

Food _____

Other _____ (specify which ones):

Excessive behaviors & needs:

Shopping _____

Socializing _____

Sex _____

Need for order, cleanliness _____

Ritual behaviors _____

(please give specifics) _____

Other (specific which)

Grooming: 1 2 3 4 5 (best)

Motor (please rate the ff. 1 (best)-1 (worst))

Ease of movement _____

Large muscle coordination (arms, legs, trunk) _____

Balance _____

Social (please rate the following 1-10)

Aware of own emotions _____

Facial recognition & memory _____

Reading nonverbal cues in others _____

Recognition of the emotions of others/empathy _____

Sense of adequacy for life tasks _____

Attractiveness to others _____

Self-esteem _____

Sense of isolation _____

Sudden loss or absence of feelings _____

Intuitiveness _____

Past traumatic experience that has continuing negative impact _____

Outlook & Social Support

Kindly rate your best friendship in terms of:

a) trust: 1 2 3 4 5 (most)

b) satisfaction: 1 2 3 4 5 (most)

Are you presently in a romantic relationship? Yes No

Are you currently needed by at least one person whom you like?

Yes No

How expressive are you of gratitude for the relationships and positive aspects of your current life?

1 2 3 4 5 (most)

What else is important for us to know about you (for example current or past life stressors)?

Sleep Patterns

- Difficulty falling asleep
- Restless sleep
- Awakening in the night due to:
 - Urination
 - Dreams
 - Hunger
 - Pain
 - Apnea
 - Other/unknown _____
- How long to return to sleep: _____
- Excessive sleeping
- Sleepwalking
- Night sweats
- Snoring

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- Teeth grinding (bruxism)
- Talking when asleep
- Difficulty awakening
- Sleep aids (*medications and supplements*)

Accidents & Trauma

_____ Age _____
 _____ Age _____
 _____ Age _____
 _____ Age _____

Surgical procedures

_____ Age _____
 _____ Age _____
 _____ Age _____
 _____ Age _____

Nutritional

- Unhealthful diet
- Poor appetite
- Weight loss
- Increased appetite
- Recent weight gain
- Overweight
- Major food cravings (which ones):

Frequency of eating fish (times/wk)

- 1x/mo. 2x/mo. 1x/wk 2+x/wk
- Nutritional supplements

List those taken regularly:

Supplements believed to be most beneficial:

Types of cookware used:

- Aluminum Stainless steel
- Pyrex Glass
- Enamel Teflon
- Cast Iron Copper

Toxins

- Sensitive reactions to chemicals
(*explain*) _____
- Known exposure to mercury, lead, toxic chemicals, radiation, etc. (*describe*)

Towns/cities where pt. has lived:

- Lived in home remodeling project:

If yes, when & how long?

Heart and Chest

- Tightness or pain in chest
- Heart palpitations
- Racing heart
- Rapid breathing (not under exertion)
- Asthma, wheezing
- Shortness of breath
- Repeated nose or chest colds
- Other: _____

Gastrointestinal & Hepatic

- Difficulty swallowing
- Nausea or vomiting
- Abdominal (stomach/belly) pain
- Frequent belching or gas
- Vomiting blood
- Anal itching
- Rectal bleeding (red or black stool)
- Encopresis (soiling)
- Enuresis (wetting)
- Jaundice (yellowing of skin)
- Gastric reflux

Bowels:

- Painful movements
- Infrequent movements
- Irregularity
- Constipation
- Liquid bowel movements
- Loss of bowel control
- Frequency: _____
- Color _____
- Consistency _____
- Other _____

Males

- Hormone problems
- Erectile or sexual problem/concern
- Early hair loss

Females

- No menses
- Menstrual:
 - Bloating
 - Cramps
 - Headache
 - Tension
 - Moodiness
 - Irritability, Anger
 - Irregularity
 - Heavy periods

