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

Name: _____ **Ψ Lifetime Development Adult Intake Medical History** **D.O.B.**_____ **Today's Date**_____

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 pecifics)*_____
_____
_____
□ 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

□ 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

□ Painful periods
□ Painful intercourse or sex
□ Sterility or infertility
□ Vaginal discharge
□ Hot flashes

Genitourinary

□ Itchy privates or genitals
□ Painful urination
□ Excessive urination
□ Difficulty in starting urine
□ Accidental wetting of self
□ Pus or blood in urine
□ Bedwetting pain or stiffness
□ Other: _____
_____

Musculoskeletal

□ Joint pain
□ Leg pain
□ Muscle cramps
Other physical pain or disability (*describe*):

_____
_____
_____
_____

Head, Eye, Ear, Nose & Throat

□ Head injury *(when?)*_____
□ Facial or jaw pain
□ Frequent sore throat
□ Blurred vision
□ Double vision
□ Very sensitive to light
□ Hearing loss
□ See spots or shadows
□ Ringing in ears
□ Fragrance sensitivity
□ Runny nose
□ Dry mouth
□ Sore tongue
□ Frequent ear infections
□ Had ear tubes
□ Other:_____

Listening difficulties often develop early in life. Please note if any of the following apply:

__Experienced emotional trauma
__Had frightening experiences
__Had dangerous experiences
__Exposed to loud sounds (*e.g.*, gunshots, loud concerts)

Skin, Hair

□ Dry hair or skin
□ Itchy skin or scalp
□ Hair loss
□ Easy bruising
□ Sun sensitivity
□ Acne
□ Other:_____
_____
_____
_____
_____
_____
_____

Notes & Additional Information: