THERAPY SERVICES with Dennis Dyck, Ph.D
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DEVELOPMENTAL INVENTORY

Name: _____ **Date:** _____

Age: _____ **Sex:** ☐ **Male** ☐ **Female** ☐ **T or Q** **Date of Birth:** _____

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? _____ lbs. _____ oz.
4. Did you have any trouble starting to breathe or any trouble in the hospital? ☐ No ☐ Yes
5. Did you remain in the hospital after your mother went home? ☐ No ☐ Yes

II. Development

Did you sit, walk, talk, and learn as quickly as other children in your family? ☐ No ☐ Yes

III. Family—Social History

1. Are your parents in good health? ☐ No ☐ Yes
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
3. Did you experience any significant losses or stressful events growing up? ☐ No ☐ Yes
   If yes, please explain: _____
4. Any significant stressful events and or losses in your life recently? ☐ No ☐ Yes
   If yes, please explain: _____
5. What is your identified cultural or ethnic background? _____
6. Do you consider yourself a spiritual or religious person? ☐ No ☐ Yes
   If yes, what faith/denomination? _____

IV. Infections and Illnesses

1. Have you ever had:
   - Any trouble hearing or seeing? ☐ No ☐ Yes
   - More than fifteen (15) absences from work last year? ☐ No ☐ Yes
   - Convulsion, fainting spell, or seizure? ☐ No ☐ Yes
   - Fever over 101 degrees? ☐ No ☐ Yes
   - Highest temperature? _____ how long? _____
   - Major illness or disease? ☐ No ☐ Yes
     Please list: _____
   - To stay in hospital overnight? ☐ No ☐ Yes
     Why? _____

2. Have you taken any medication for an extended period of time? ☐ No ☐ Yes
If so, please list medications and reasons for taking medications:

_____

3. Any other health problems, which might influence your learning or activity, i.e., heart problems, diabetes, kidney problems, hyperactivity? Please explain: _____

_____

_____

V. Accidents

Have you ever had any serious injuries or accidents? ☐ No ☐ Yes
Please check all that apply:
☐ Poisoning ☐ Broken Bones ☐ Loss of Consciousness ☐ Head Injury
☐ Car Accident or other Trauma

VI. Behavior

1. How well did you do in school? _____

_____

2. Did you repeat any grade? ☐ No ☐ Yes Which grade? _____
3. Do you have any learning disabilities? ☐ No ☐ Yes What are they? _____

_____

4. Are you worried about any work problems? ☐ No ☐ Yes
If yes, please list: _____

_____

5. Do you have any concerns about your social or family relationships? ☐ No ☐ Yes
If yes, what are they? _____

_____

6. Are you concerned about any of the following? (Check all that apply)

☐ Anxiety or fears	☐ Social avoidance	☐ Self esteem issues
☐ Over activity	☐ Irritability or anger	☐ Depression
☐ Worries	☐ Impulse control problems	☐ Poor concentration
☐ Obsessions	☐ Trouble with the law	☐ Difficulty sustaining attention
☐ Jealousy	☐ Appetite problems	☐ Trouble learning
☐ Shyness	☐ Weight gain or loss	☐ Memory problems
☐ Nail biting	☐ Sleep problems	☐ Substance abuse

Please note the date of your last complete physical: _____

How often have you seen your doctor in past year? Give number of times: _____

Signature: _____ Date: _____