

| | Yes | No | Unsure |
|--|-----|----|--------|
| During her pregnancy with you, did your mother have any medical problems? | | | |
| Required bedrest or hospitalization for medical problems? | | | |
| Used alcohol or non-prescribed drugs? | | | |
| Smoked cigarettes? | | | |
| Was exposed to lead, solvents, or toxic substances? | | | |
| Had pre-eclampsia? (high blood pressure due to pregnancy) | | | |
| Suffered a serious physical injury? | | | |
| Suffered severe morning sickness? | | | |
| | | | |
| During your birth, were there problems or complications? | | | |
| Premature birth? | | | |
| Cord wrapped around you at birth? | | | |
| Forceps used during delivery? | | | |
| Lack of oxygen or fetal distress? | | | |
| Low APGAR scores/poor vital signs at birth? | | | |
| Treated in an infant Intensive Care Unit after your birth? | | | |
| Any other birth complications? | | | |
| If yes, please specify: | | | |
| | | | |
| Did you experience any delays in development as a child? | | | |
| Walking late (after 1 year of age)? | | | |
| Talking late (after 2 years of age)? | | | |
| Bedwetting (after 5 years of age)? | | | |
| Tics or involuntary movements? | | | |
| Other developmental problems? | | | |
| If yes, please specify: | | | |
| | | | |
| Did you experience any learning problems in elementary school? | | | |
| Were you diagnosed with attention deficit or hyperactivity? | | | |
| Were you diagnosed with a learning disability? | | | |
| Type: | | | |
| Were you diagnosed as retarded or developmentally disabled? | | | |
| Were you placed in ungraded or special classrooms? | | | |
| Did you receive special education services? | | | |
| Type: | | | |
| Did you have an IEP? | | | |
| Did you have speech therapy or physical therapy? | | | |
| Did you repeat any grades? | | | |
| List grades repeated: | | | |
| Did you fail classes in high school? | | | |
| List classes failed: | | | |

| | Yes | No | Unsure |
|--|-----|----|--------|
| Did you have behavior problems before age 15? | | | |
| Were you often truant from school? | | | |
| Did you run away from home? | | | |
| Did you start physical fights? | | | |
| Did you use a weapon in fights? | | | |
| Did you force someone to have sex with you? | | | |
| Were you ever physically cruel to animals? | | | |
| Were you ever physically cruel to other people? | | | |
| Did you deliberately destroy others' property? | | | |
| Did you ever engage in fire-setting? | | | |
| Did you often lie? | | | |
| Did you steal without confronting a person? (shoplift?) | | | |
| Did you steal with confronting a person? (mugging?) | | | |
| | | | |
| Did you have any of the following problems as a child/teen? | | | |
| Poor coordination | | | |
| Problems with arithmetic or math | | | |
| Problems with art, drawing, or putting things together? | | | |
| Trouble following travel directions or getting lost frequently? | | | |
| Difficulty interpreting the emotions of others? | | | |
| Extreme shyness or awkwardness in social situations? | | | |
| Difficulty making friends or a tendency to be socially isolated? | | | |
| Difficulty with sexual identity or intimacy? | | | |
| | | | |
| Did your teachers or parents describe you as a child who: | | | |
| Could not concentrate or pay attention for long? | | | |
| Couldn't sit still? | | | |
| Was restless or hyperactive? | | | |
| Was fidgety? | | | |
| Daydreamed or got lost in your thoughts? | | | |
| Had difficulty following directions? | | | |
| Talked out of turn? | | | |
| Talked too much? | | | |
| Did messy work? | | | |
| Failed to finish things you started? | | | |
| Was easily distracted? | | | |
| Failed to carry out assigned tasks? | | | |
| Had temper tantrums or was easily angered? | | | |
| | | | |
| As an adult, have you had any of the above problems? | | | |
| List: | | | |
| | | | |
| | | | |
| | | | |

| | Yes | No | Unsure |
|---|-----|----|--------|
| As an adult, have you had any of the following problems? | | | |
| Difficulty holding a job? | | | |
| Frequent job changes? | | | |
| Repeated absences from work? | | | |
| Physical fights with friends, family, or strangers? | | | |
| Failure to pay debts, loans, child support? | | | |
| Bankruptcy? | | | |
| Sudden or unplanned travel? | | | |
| Homelessness? | | | |
| Conned people or lied for personal gain? | | | |
| Used an alias? | | | |
| Had a tendency to speed while driving? | | | |
| Any driving while intoxicated? | | | |
| Engaged in dangerous or thrill-seeking activities? | | | |
| Neglected the care of children? | | | |
| Spent money needed for household necessities? | | | |
| Had problems being faithful to your spouse? | | | |
| Had disciplinary problems in the military? | | | |
| Been arrested? | | | |
| Describe: | | | |
| | | | |
| Have you had any of the following neurologic problems? | | | |
| Head injury with loss of consciousness or confusion? | | | |
| Seizures or epilepsy | | | |
| Stroke, brain hemorrhage, or TIA | | | |
| Meningitis, encephalitis, brain infection | | | |
| Brain tumor | | | |
| Fainting or dizzy spells | | | |
| Loss of oxygen, choking, drowning, suffocation | | | |
| Drug or alcohol overdose | | | |
| Exposure to toxic substances | | | |
| Syphilis or other venereal disease | | | |
| Severe or persistent headache or migraine | | | |
| Parkinson's disease, tremor, movement disorder | | | |
| Alzheimer's disease or other dementia | | | |
| Multiple sclerosis | | | |
| Other neurologic disease or damage? | | | |
| Specify: | | | |
| | | | |
| Have you seen a neurologist? | | | |
| Name: _____ Date: _____ | | | |
| Have you had a CT scan or MRI scan of the brain? | | | |
| Results: _____ Date: _____ | | | |
| Please list or bring results with you. | | | |

| | Yes | No | Unsure |
|---|-----|----|--------|
| Have you had any of the following general medical problems? | | | |
| Heart attack or heart failure | | | |
| High blood pressure | | | |
| Liver disease, hepatitis, cirrhosis, jaundice | | | |
| Kidney disease or dialysis | | | |
| Diabetes | | | |
| Thyroid disease | | | |
| Vitamin deficiency | | | |
| Cancer | | | |
| Other serious medical problem | | | |
| Specify: | | | |
| | | | |
| Have you had any psychiatric treatment? | | | |
| Counseling? | | | |
| Prescribed medication for emotional/psychiatric problems? | | | |
| Hospitalization for emotional/psychiatric problems? | | | |
| Dates: | | | |
| Treated with ECT, vagus nerve stimulator, transcranial magnetic stimulation, or other outpatient procedure? | | | |
| | | | |
| Has anyone in your FAMILY had a neurologic condition? | | | |
| Seizures or epilepsy | | | |
| Stroke, brain hemorrhage, TIA | | | |
| Brain tumor | | | |
| Multiple sclerosis | | | |
| Parkinson's disease or movement disorder | | | |
| Alzheimer's disease or dementia | | | |
| Other | | | |
| Specify: | | | |
| | | | |
| Has anyone in your family had a psychiatric disorder? | | | |
| Specify: | | | |
| | | | |
| Have you had any problems with alcohol or drugs? | | | |
| Treatment for alcohol abuse or drug abuse? | | | |
| Have you attended AA, NA, or other self-help program? | | | |
| Do you drink alcohol at all now? | | | |
| Do you use any non-prescribed drugs? | | | |
| List: | | | |
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