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For Office Use

Patient History Questionnaire

Patient's Name: ______________________________ Today's Date ______________________
____

Sex/Gender: __________ Date of birth: __________ Age: ______ Race/Ethnicity ______________

Form completed by (if someone other than patient) ______________________________

Primary reason(s) for seeking services:

❑ Anger management ❑ Anxiety ❑ Coping ❑ Academic performance concerns
❑ Eating concerns ❑ Fear/phobias ❑ Moodiness/irritability ❑ Risky behaviors
❑ Sleeping problems ❑ Compulsions ❑ Depression ❑ Hyperactivity/impulsivity
❑ Acting out Behaviors ❑ Other concerns (specify): ______________________________

Parent/Guardian/Sibling Information:

With which caregivers does the patient live at this time? ______________________________

Are parent's divorced or separated? ❑ No ❑ Yes If Yes, who has legal custody? ________________ ❑ N/A

Step-parent's Name(s)/relationship ______________________________

Patient's Parent/Guardian 1

Name: ______________________ Age: ______ Race/Ethnicity ______________

Currently Employed? ❑ No ❑ Yes, as __________ Parent's/Guardian education ______________

❑ Biological parent ❑ Step-parent ❑ Adoptive Parent ❑ Legal Guardian ❑ Other ______________

Patient's Parent/Guardian 2

Name: ______________________ Age: ______ Race/Ethnicity ______________

Currently Employed? ❑ No ❑ Yes, as __________ Parent's/Guardian education ______________

❑ Biological parent ❑ Step-parent ❑ Adoptive Parent ❑ Legal Guardian ❑ Other ______________

Name of Siblings	Age	Sex/Gender	Relationship	Lives	Quality of relationship with the Patient________
__________	_____	_______	❑ bio ❑ step/adopted ❑ half	❑ home ❑ away	❑ poor ❑ average ❑ good
__________	_____	_______	❑ bio ❑ step/adopted ❑ half	❑ home ❑ away	❑ poor ❑ average ❑ good
__________	_____	_______	❑ bio ❑ step/adopted ❑ half	❑ home ❑ away	❑ poor ❑ average ❑ good
__________	_____	_______	❑ bio ❑ step/adopted ❑ half	❑ home ❑ away	❑ poor ❑ average ❑ good
__________	_____	_______	❑ bio ❑ step/adopted ❑ half	❑ home ❑ away	❑ poor ❑ average ❑ good

Patient's Name: _____
DOB: _____

Additional Persons Living in Household N/A. I am 18 years old or older and I live alone.

Name	Age	Sex/Gender	Relationship (e.g., grandparent, stepparent)	Quality of relationship with the Patient
_____	____	_____	_____	❑ poor ❑ average ❑ good
_____	____	_____	_____	❑ poor ❑ average ❑ good
_____	____	_____	_____	❑ poor ❑ average ❑ good
_____	____	_____	_____	❑ poor ❑ average ❑ good

Childhood/Adolescent Developmental History

Pregnancy/Birth

Any prenatal medical/emotional difficulties for the mother? (e.g., surgery, hypertension, depression) ❑ No ❑ Yes, describe: ___

_____

Any medications taken by mother during pregnancy:) ❑ No ❑ Yes, describe: _____

Any alcohol or street drugs taken by mother during pregnancy:) ❑ No ❑ Yes, describe: _____

Was the baby premature? ❑ No ❑ Yes, weeks at birth_____ Birth weight: _____ pounds_____ inches

Describe any birth problems or complications: _____

Describe any complications for the mother or the baby after the birth: _____

Infancy/Toddlerhood Check all which apply: ❑ I am 18 years old or older; Information not available

❑ Breastfed	❑ Bottle fed	❑ Milk allergies	❑Other Allergies:_____	
❑ Vomiting	❑ Diarrhea	❑ Constipation	❑ Colic	❑ Rashes
❑ Not cuddly	❑ Cried often	❑ Rarely cried	❑ Overactive	❑ Lethargic
❑ Resisted solid food	❑ Trouble sleeping	❑ Irritable when awakened		

Developmental Milestones Please note the age at which the following behaviors took place: :

❑ I am 18 years old or older; Information not available

Sat alone: (6-10mo) _____ Crawled:(6-10 mo) _____ Walked:(12 mo) _____Fed self: (2 yrs) _____

Spoke words: (18-24mo) _____ Dry all day:(2.5-4yrs) _____Dry all night: (2.5-4 yrs) _____

Compared with others in the family, child's development was: ❑ early ❑ average ❑ late

How would you describe your child's approach to new situations?
❑ Positive, jumps right in ❑ Withdrawn, tends not to participate ❑ Slow to Warm up, cautious

How would you describe your child's overall mood?
❑ Positive: happy, laughing, upbeat ❑ Negative: depressed, angry, hostile ❑ Mixed but more positive ❑ Mixed but more negative

Education ❑ Patient is not currently in school. Highest level of education achieved:_____

Current school: _____ Grade/Year in school: _____

Receiving any special education services? ❑ No ❑ Yes, describe: _____

In gifted program? ❑ No ❑ Yes, describe: _____

Favorite Subjects _____ Least Favorite Subjects _____

Patient's Name: _____
DOB: _____

Any additional notes about the patient's education that you would like to include? _____

_____

Employment ❑ N/A. Patient is under 16 years old.

My current employment is_____ ❑ N/A. Not employed.

Medical/Physical History (pertaining to the Patient; check all that apply; [C]=current or [P]=past)

[C] [P] Allergies	[C] [P] Earaches/infections	[C] [P] Multiple sclerosis	[C] [P] Scarlet fever
[C] [P] Asthma	[C] [P] Encephalitis	[C] [P] Mumps	[C] [P] Seizures
[C] [P] Blackouts	[C] [P] Eczema	[C] [P] Muscular dystrophy	[C] [P] Severe colds
[C] [P] Bronchitis	[C] [P] Hay fever	[C] [P] Nose bleeds	[C] [P] Severe head injury
[C] [P] Cerebral Palsy	[C] [P] Heart trouble	[C] [P] Other skin rashes	[C] [P] STD/STI
[C] [P] Chicken pox	[C] [P] Hepatitis	[C] [P] Paralysis	[C] [P] Thyroid disorders
[C] [P] Congenital problems	[C] [P] Hives	[C] [P] Pneumonia	[C] [P] Vision problems
[C] [P] Croup	[C] [P] Influenza	[C] [P] Polio	[C] [P] Wearing glasses
[C] [P] Diabetes	[C] [P] Lead poisoning	[C] [P] Pregnancy	[C] [P] Whooping cough
[C] [P] Diptheria	[C] [P] Measles	[C] [P] Rheumatic fever	[C] [P] Other _____
[C] [P] Dizziness	[C] [P] Meningitis		_____

If any of the above are checked please explain _____

_____

Primary Doctor _____ **Practice Name** _____

List any hospitalizations, significant accidents and/or surgeries _____

_____

All current prescribed/herbal/ over-the-counter medications	Dose	Dates	Purpose	Side effects

Any recent health or physical changes? _____

_____

Psychological/Psychiatric Treatment History

	No	Current	Past	When	Where	Purpose
Therapy/counseling treatment	❑	[C]	[P]			
Psychiatric Treatment	❑	[C]	[P]			
Drug/alcohol treatment	❑	[C]	[P]			
Psychiatric hospitalizations	❑	[C]	[P]			
Psychological testing	❑	[C]	[P]			

Patient's Name: _____
DOB: _____

Current Behavioral/Emotional Concerns (pertaining to the Patient; check all that apply; [C]=current or [P]=past)

[C] [P] Suicidal thoughts	**[C] [P] Aggression**	**[C] [P] Eating Disorder**	**[C] [P] Family Conflict**
[C] [P] Suicidal threats	**[C] [P] Threats/Bullying**	**[C] [P] Bullied by others**	**[C] [P] Physical abuse**
[C] [P] Suicidal attempts	**[C] [P] Hurts Animals**	**[C] [P] Sexual acting out**	**[C] [P] Sexual Abuse**
[C] [P] Self-harm Behaviors	**[C] [P] Alcohol/drug use**	**[C] [P] Hallucinations**	**[C] [P] Emotional Abuse**
[C] [P] Angry	[C] [P] Destructive	[C] [P] Lies frequently	[C] [P] Sleeping issues
[C] [P] Anxious	[C] [P] Thumb sucking	[C] [P] Withdrawn	[C] [P] Panic attacks
[C] [P] Hopelessness	[C] [P] Frustrated easily	[C] [P] Low self-esteem	[C] [P] Eating disorder
[C] [P] Short attention span	[C] [P] Separation anxiety	[C] [P] Talks back	[C] [P] Speech problems
[C] [P] Impulsive	[C] [P] Poor appetite	[C] [P] Nightmares	[C] [P] Stomachaches
[C] [P] Tics or twitching	[C] [P] Bedwetting	[C] [P] Overweight	[C] [P] Defiant
[C] [P] Learning problems	[C] [P] Sick often	[C] [P] Sad/Depressed	[C] [P] Fatigue
[C] [P] Clumsy	[C] [P] Shy, timid	[C] [P] Fearful	[C] [P] Dizziness
[C] [P] Steals	[C] [P] Irritable	[C] [P] Worries excessively	[C] [P] Teeth grinding
[C] [P] Cyber addiction	[C] [P] Phobias	[C] [P] Unusual thinking	[C] [P] Weight loss/gain
[C] [P] Moody	[C] [P] Soiling	[C] [P] Overactive	

What would you describe as the patient's strengths or positive qualities? _____

_____

What are your goals for the patient? _____

_____

Any additional information that you believe would assist us in understanding the patient? _____

_____

_____

Hobbies/Recreation

Describe special talents or hobbies (e.g., books, sports, outdoor activities, church/school activities, scouts, etc.) _____

_____