Canby Healthcare Clinic

Personal History Questionnaire: Parent/Guardian (Patient's information)

Form completed by: _____

I am related to patient through: ☐ Birth ☐Adoption ☐Fostering ☐Other			
Patient name:	DOB:	Age:	Gender:
Guardian 1: Name:		Relationship to patient:	
☐ Address same as patient primary address			
Primary address:	City:	State:	Zip:
Telephone (home):	(work)	(cell)	
Ok to leave message at ☐home ☐work ☐cell			
Guardian 2: Name:	Relationship to patient:		
☐Address same as patient primary address			
Primary address:	City:	State:	Zip:
Telephone (home):	(work)	(cell)	
Ok to leave message at ☐home ☐work ☐cell			
Alternative emergency contact:	Relationship:	Phone:	
Name of current therapist/psychiatric provider		Phone:	

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Mental health/Psychiatric history

Please mark any symptoms your patient experiences Currently or in the Past.								
C	P		C	P		C	P	
☐	☐	Depressed/sad mood	☐	☐	Muscle tension	☐	☐	Relationship problems
☐	☐	Reduced interest in activities	☐	☐	Excessive worry	☐	☐	Eating problems
☐	☐	Appetite/weight change	☐	☐	Panic symptoms	☐	☐	Drug or alcohol problems
☐	☐	Frequent crying/tearfulness	☐	☐	Boredom	☐	☐	Gambling problems
☐	☐	Low self-esteem	☐	☐	Impulsivity	☐	☐	Sexual problems
☐	☐	Low motivation	☐	☐	Distractibility	☐	☐	Computer addiction
☐	☐	Social isolation	☐	☐	Hyperactivity	☐	☐	Problems with pornography
☐	☐	Feelings of hopelessness	☐	☐	Abnormally elevated mood for several uninterrupted days	☐	☐	Work/school problems
☐	☐	Seasonal mood changes	☐	☐		☐	☐	Parenting problems
☐	☐	Loneliness	☐	☐	Racing thoughts	☐	☐	Suspiciousness/paranoia
☐	☐	Feelings of guilt/shame	☐	☐	Excessive energy	☐	☐	Hearing or seeing things
☐	☐	Sleeping too much or too little	☐	☐	Flashbacks	☐	☐	Irritability
☐	☐	Low energy/fatigue	☐	☐	Nightmares	☐	☐	Frequent anxiety
☐	☐	Excessive thoughts of death	☐	☐	Easily startled	☐	☐	Fear away from home
☐	☐	Poor concentration	☐	☐	Anger outbursts	☐	☐	Obsessions/compulsions
☐	☐	Restlessness or feeling on edge/keyed up	☐	☐	Excessive fears			
☐	☐	Difficulty thinking or making decisions	☐	☐	Excessive social discomfort			
Are any of the above symptoms affecting the patient's:								
☐ Ability to engage in their normal daily activities ☐ school ☐ recreational activities ☐ relationships ☐ health ☐ happiness ☐ spirituality ☐ self esteem								

General Health/Medical History

Primary Care Provider Name:	Last visit:
Medication allergies:	
Ongoing medical problems:	
Past medical problems:	
Family medical problems:	

Current Medications:

Pregnancy/Birth

Known substance/toxin exposure during pregnancy? ☐ Cigarettes ☐Alcohol ☐Drugs ☐Other List:	
List any complications during pregnancy:	
Type of delivery ☐ Vaginal ☐ C-section	Gestational age at birth:
Did mother experience “baby blues” (postpartum depression)? ☐Yes ☐No	If yes, did she seek treatment?
Describe any prolonged separation from parent(s) during infancy:	
Did he/she meet his/her developmental milestones on time?	If no, describe.

Is there anything else you’d like us to know about the child?

Thank you for taking the time to complete this questionnaire.