



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

Form completed by: _____

I am related to patient through: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Fostering <input type="checkbox"/> Other			
Patient name:	DOB:	Age:	Gender:
Guardian 1: Name:		Relationship to patient:	
Name of current therapist/psychiatric provider		Phone:	

Mental health/Psychiatric history

Please mark any symptoms your patient experiences Currently or in the Past.

C	P		C	P		C	P	
<input type="checkbox"/>	<input type="checkbox"/>	Depressed/sad mood	<input type="checkbox"/>	<input type="checkbox"/>	Muscle tension	<input type="checkbox"/>	<input type="checkbox"/>	Relationship problems
<input type="checkbox"/>	<input type="checkbox"/>	Reduced interest in activities	<input type="checkbox"/>	<input type="checkbox"/>	Excessive worry	<input type="checkbox"/>	<input type="checkbox"/>	Eating problems
<input type="checkbox"/>	<input type="checkbox"/>	Appetite/weight change	<input type="checkbox"/>	<input type="checkbox"/>	Panic symptoms	<input type="checkbox"/>	<input type="checkbox"/>	Drug or alcohol problems
<input type="checkbox"/>	<input type="checkbox"/>	Frequent crying/tearfulness	<input type="checkbox"/>	<input type="checkbox"/>	Boredom	<input type="checkbox"/>	<input type="checkbox"/>	Gambling problems
<input type="checkbox"/>	<input type="checkbox"/>	Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	Sexual problems
<input type="checkbox"/>	<input type="checkbox"/>	Low motivation	<input type="checkbox"/>	<input type="checkbox"/>	Distractibility	<input type="checkbox"/>	<input type="checkbox"/>	Computer addiction
<input type="checkbox"/>	<input type="checkbox"/>	Social isolation	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Problems with pornography
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	Abnormally elevated mood for several uninterrupted days	<input type="checkbox"/>	<input type="checkbox"/>	Work/school problems
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal mood changes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Parenting problems
<input type="checkbox"/>	<input type="checkbox"/>	Loneliness	<input type="checkbox"/>	<input type="checkbox"/>	Racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Suspiciousness/paranoia
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of guilt/shame	<input type="checkbox"/>	<input type="checkbox"/>	Excessive energy	<input type="checkbox"/>	<input type="checkbox"/>	Hearing or seeing things
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping too much or too little	<input type="checkbox"/>	<input type="checkbox"/>	Flashbacks	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Low energy/fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Excessive thoughts of death	<input type="checkbox"/>	<input type="checkbox"/>	Easily startled	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	Anger outbursts	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Restlessness or feeling on edge/keyed up	<input type="checkbox"/>	<input type="checkbox"/>	Excessive fears			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty thinking or making decisions	<input type="checkbox"/>	<input type="checkbox"/>	Excessive social discomfort			
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Obsessions/compulsions			
<input type="checkbox"/>	<input type="checkbox"/>	Frequent anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Fear away from home			

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



Has the patient been diagnosed with mental health/psychiatric problems in the past? <input type="checkbox"/> Yes <input type="checkbox"/> no		
Diagnosis	Age	By whom?

Pregnancy/Birth

Known substance/toxin exposure during pregnancy? <input type="checkbox"/> Cigarettes <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Other List:	
List any complications during pregnancy:	
Type of delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section	Gestational age at birth:
Did mother experience "baby blues" (postpartum depression)? <input type="checkbox"/> Yes <input type="checkbox"/> 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.