

Personal History Questionnaire: Teen

General

Name		DOB	Age
Gender:	Gender assigned at birth if different than current:		Preferred pronoun:
Telephone (home)		(Mobile)	
May I leave a message for you at home? <input type="checkbox"/> Yes <input type="checkbox"/> No		On mobile phone? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Mental health/Psychiatric history

Please mark any symptoms you experience 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			



Canby Healthcare Clinic

Are any of the above symptoms affecting your:

- Ability to engage in you 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:

What is your goal from this visit/treatment from this provider?

Thank you for taking the time to complete this questionnaire.