Canby Healthcare Clinic

Personal History Questionnaire: Parent/Guardian (Child'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 child 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	☐	☐	Other:
☐	☐	Low energy/fatigue	☐	☐	Nightmares	☐	☐	Other:
☐	☐	Excessive thoughts of death	☐	☐	Easily startled	☐	☐	Other:
☐	☐	Poor concentration	☐	☐	Anger outbursts	☐	☐	Other:
☐	☐	Restlessness or feeling on edge/keyed up	☐	☐	Excessive fears			
☐	☐	Difficulty thinking or making decisions	☐	☐	Excessive social discomfort			
☐	☐	Irritability	☐	☐	Obsessions/compulsions			
☐	☐	Frequent anxiety	☐	☐	Fear away from home			

General Health/Medical History

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

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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?

Social Development

What was the child like as an infant?	
Did he/she make eye contact as an infant? ☐Yes ☐ No	Did he/she seek interaction? ☐Yes ☐ No
Did he/she demonstrate curiosity about the environment in the first three years? ☐Yes ☐ No	
Is there a history of separation anxiety? ☐ Yes ☐No	Stranger anxiety? ☐Yes ☐ No
What is the child's activity level in general? ☐High ☐Low ☐ Moderate	
How predictable is the child's behavior? ☐ Very predictable ☐ so-so ☐ Unpredictable	
How does the child respond to something new? ☐Approaches ☐Withdraws ☐Watches	
How does the child transition/adapt to novelty or change? ☐Easily ☐ with difficulty	
How much stimulus is required before the child reacts? ☐ a lot ☐ a little	
Do you find yourself 'walking on egg-shells' with him/her? Describe.	
Describe the child's persistence: for example, does he/she continue to work on projects despite obstacles or give up easily?	
Is the child easily distractible? ☐Yes ☐No Forgetful? ☐ Yes ☐ No	
Child's current play behaviors (check all that apply) ☐ Prefers to play alongside others ☐ Prefers to play cooperatively ☐Prefers to play with older children ☐ Prefers to play with youngers children ☐Prefers to play alone ☐Accident prone ☐ Controlling ☐Can't tolerate losing ☐ Difficulty taking turns ☐ Difficulty sharing ☐ Reckless ☐ Cautious ☐ Aggressive	
Describe any concerns you have about his/her social skills or behavior:	
Please indicate how many hours a day the child spends on TV: Computer: Videogames: Other screens:	
Describe any household chores/duties child is responsible for:	

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Who is the primary disciplinarian?	Is discipline consistent? ☐Yes ☐No	If no, why not?
Describe the form of discipline used at home:	Child's response:	

Trauma exposure

Natural disaster:
Loss of parent/significant other:
Domestic violence:
Abuse/neglect/abandonment:

Motor Development

Sat alone age:	Crawled/creeped age:	Walked alone age:
Picked up small items age:	Undressed self at what age:	Dressed self at what age:
Current motor skills: ☐Agile ☐ Coordinated ☐ Clumsy ☐ Awkward ☐ Accident prone Describe:		
Describe concerns you have about the child's fine or gross motor skills:		

Speech and Language Development

Primary language: Spoke first word age:	Does child gesture? ☐Yes ☐No
How does the child let you know his/her wants or needs?	
How does the child let you know he/she understands what you say?	
What percentage of child's speech do you understand? ☐25% ☐50% ☐75% ☐100%	
What percentage do unfamiliar listeners understand? ☐ 25% ☐50% ☐75% ☐100%	

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Feeding Development

Describe any feeding difficulties: Current appetite: ☐Poor ☐Fair ☐Good
Eating behaviors ☐Picky ☐Overeats ☐ Refuses to eat ☐Hoards food ☐Gag/vomits ☐ Eats non-food items
Do you have any concerns about the child's eating or feeding, if so describe:
Does the child remain seated at the table throughout the meal? ☐ Yes ☐ No
The child currently uses: ☐Fingers ☐Fork ☐Spoon ☐Bottle ☐Sippy Cup ☐ Open cup
Special diets (past and present):
What does the child think about his/her weight and shape?

Toileting/Hygiene Development

Is the child currently toilet-trained? ☐Yes ☐No If yes, since when?
☐Diapers ☐Pullups ☐Underwear ☐Daytime accidents? ☐Bedwetting?
Did the child toilet train easy? ☐Yes ☐No
Please check all that apply: ☐Constipation ☐Frequent loose stool
Describe any resistance to hygiene routines:

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

Thank you for taking the time to complete this questionnaire.