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Personal History Form

Name: _____ **DOB**: _____ **Date**: _____

What is the problem/concern(s)? _____

How long has this been going on? _____

Name and Relationship of person completing this form? _____

Current Signs & Symptoms

(please also complete the form Pediatric Symptom Checklist)

Mild: Impacts quality of life, but no significant impairment of day-to-day functioning ● *Moderate*: Significant impact of quality of life and/or day-to-day functioning ● *Severe*: Profound impact on quality of life and/or day-to-day functioning

	Mild	Moderate	Severe		Mild	Moderate	Severe
depressed mood	❑	❑	❑	dissociative states	❑	❑	❑
appetite disturbance	❑	❑	❑	paranoia	❑	❑	❑
sleep disturbance	❑	❑	❑	intrusive thoughts	❑	❑	❑
urine/bowel disturbance	❑	❑	❑	delusions	❑	❑	❑
fatigue/low energy	❑	❑	❑	seeing things that are not there	❑	❑	❑
psychomotor retardation	❑	❑	❑	hearing things that are not there	❑	❑	❑
poor concentration	❑	❑	❑	aggressive behaviors	❑	❑	❑
poor grooming	❑	❑	❑	conduct problems	❑	❑	❑
mood swings	❑	❑	❑	oppositional behavior	❑	❑	❑
agitation	❑	❑	❑	sexual dysfunction	❑	❑	❑
emotionality	❑	❑	❑	grief	❑	❑	❑
irritability	❑	❑	❑	hopelessness	❑	❑	❑
generalized anxiety	❑	❑	❑	social isolation	❑	❑	❑
panic/anxiety attacks	❑	❑	❑	worthlessness	❑	❑	❑
phobias	❑	❑	❑	somatic aches/pains	❑	❑	❑
obsessions/compulsions	❑	❑	❑	self-mutilation / harm	❑	❑	❑
weight gain/loss	❑	❑	❑	medical conditions	❑	❑	❑
elevated mood	❑	❑	❑	emotional trauma victim	❑	❑	❑
hyperactivity	❑	❑	❑	physical trauma victim	❑	❑	❑
binging/purging	❑	❑	❑	sexual trauma victim	❑	❑	❑
laxative/diuretic abuse	❑	❑	❑	emotional trauma perpetrator	❑	❑	❑
anorexia	❑	❑	❑	physical trauma perpetrator	❑	❑	❑
guilt	❑	❑	❑	substance abuse	❑	❑	❑
other: _____				other: _____	❑	❑	❑

Recent Changes or Events

(moving, fire, new family member, death, loss, divorce, marriage, etc.)

Family History

Child lives with (Name & Relationship to child):
Occupation of parents/guardians:

Biological parents are: ❑ Married/Together ❑ Separated ❑ Divorced
What is the custody arrangement (legal and physical)?
What is the visitation arrangement?

Name of **Sibling**	Age	Gender	Lives at (home/away)	Quality of Relationship with client (good/fair/poor)

Name of **Other**s Living in the home	Age	Gender	Relationship to client	Quality of Relationship with client (good/fair/poor)

Pregnancy/Birth

During pregnancy, mother used:
❑ Cigarettes ❑ Wine ❑ Hard Alcohol ❑ Prescription Medication ❑ OTC medication/supplement
❑ Cigars ❑ Illegal substances: _____ ❑ Other: _____
Quantity/How much?
Frequency/How often?

Any significant events/complications about the pregnancy or delivery:

Current Relationship

❑ Never been in a relationship ❑ Not currently in a relationship ❑ Currently in a relationship
Relationship Satisfaction: ❑ Satisfied ❑ Somewhat satisfied ❑ Dissatisfied
Sexual Orientation: ❑ Heterosexual ❑ Gay/lesbian ❑ Bisexual
Comments or concerns:

Medications and Supplements (please list prescription and over-the-counter medications, vitamins, & supplements)

Who is responsible for managing the child's medications?
Is the child taking the above "as prescribed/directed"?

Medical and Surgical History (please list significant medical problems and surgeries)

(Significant medical problems of Mom/Dad/Guardian/Other in child's life):

Mental Health History **(**please list any diagnoses, therapy, treatment, and medications)

Has the child has any suicidal thoughts or attempts? If so, when?
Has the child ever been hospitalized in a psychiatric hospital? If so, when? Reason?

(Significant mental health problems of Mom/Dad/Guardian/Other in child's life):

Nutrition (please list typical foods eaten, where, how much)

Breakfast Lunch Dinner Snacks

Does the family sit down to eat together?
Any comments or concerns about food, eating, body image:

Educational

School Name: Current Grade Level:
List learning or behavior problems in school:
In Special Education? ❑ No ❑ Yes, Describe: _____
What grades does the child usually receive?
Any recent changes in child's grades:

Employment

Employer: _____ Position: _____ Hours per week: _____
Any comments or concerns:

Social Cultural History

Birthplace:
List any delays the child had in reaching developmental milestones (sitting up, walking, talking, etc.)?

Exposure to abuse: ❑ Physical ❑ Verbal ❑ Emotional ❑ Sexual ❑ Neglect

Length of time in local area:
Religion/spirituality:
Ethnicity/Cultural factors:
Identity Issues:
Disabilities:
Hobbies and activities:
Exercise:
❑ Makes friends easily ❑ Difficulty making friends ❑ Friends are much older ❑ Friends are much younger
❑ A leader ❑ A follower ❑ A loner ❑ Teased by others ❑ Teases or bullies others
Comments or concerns about child's friends or social skills:

Substance Use History (please list prescription, illicit, legal, & recreational substances)

Has the child had any substance misuse treatment? For what? When?

(Significant substance use history of Mom/Dad/Guardian/Other in child's life):

Legal History

❑ Juvenile Hall ❑ Probation ❑ Court ordered treatment
Reason:

(Significant legal problems of Mom/Dad/Guardian/Other in child's life):

Other Agencies or Systems Involved (social services, court, etc.)

Desired Result of Therapy/Services (what do you want to get out of this?)

Protective Factors – Strengths
Support person/system:

Current coping strategies:

Other
What family involvement would you like to see in therapy?
Is there anything you would like me to know about your child or family?
Any questions for me?