ZUMBRO VALLEY PSYCHOLOGICAL SERVICES
Child/Adolescent Personal History Questionnaire

Form Completed By:_____ **Date:** _____

Child's Name: _____ **Age:** ____ **Birthdate:** _____

What is the problem that is bringing you here?_____

_____.

What are some examples of behavior that you are concerned about? _____

_____

_____

When did the problems begin? _____

How would you like things to be different? _____

What have you already done to solve the problem? _____

Check behaviors that apply to your child/adolescent now:

___argues	___physical aggression	____easily annoyed	___steals
___rebellious	___cruel to animals	____destroys property	___ lies
___lights fires	___easily frustrated	____overreacts	___tense
___misses school	___physical complaints	____worries	___fearful
___temper tantrums	___defies requests	____blames others	___fidgets
___vindictive	____distractible	____dislikes homework	___forgetful
___impulsive	____short attention span	____cries easily	___sad
___withdrawn	____ suicidal thoughts	____suicide attempts	___moody
___motor or vocal tics	____sleep problem	___ apathy	
___self-harming behaviors			

odd or peculiar behaviors (please describe): _____
___other (please describe):_____

If your child has ever been physically or sexually abused, please describe: _____
_____

Has your child had any difficulty with the law?_____**Yes** _____**No**

Offenses:_____

Probation Officer:_____

Are there other professionals involved with your child (school counselor, social workers, foster parents, pediatrician)? _____

_____

Are you aware of any drug or alcohol use by your child? If yes, please describe: _____

SCHOOL AND SOCIAL HISTORY

What school does your child go to? _____ Grade _____

Does your child have an Individualized Education Plan (IEP) _____ Yes _____ No

If yes, what are the special needs and what services does s/he receive? _____

_____

_____.

Please bring a copy of the IEP to your next session.

Please tell us how you think your child does in school (academics, teachers, peers)? _____

_____

Please describe how your child does with friends:_____.

PREVIOUS EVALUATIONS OR MENTAL HEALTH SERVICES (please describe):

_____

_____

_____

MEDICAL HISTORY:

Serious illnesses/Serious injuries_____

Allergies_____

Current medications_____

Hospitalizations_____

Date of last physical exam_____

Name & address of child's doctor: _____

Please check if your child has experienced the following:

___asthma	___frequent ear infections	___hearing problems	___vision problems
___dental problems	___skin problems	___hayfever/allergies	___severe headaches
___seizures	___high blood pressure	___dizziness	___bed wetting
___soils underwear	___urinary infections	___constipation	___diarrhea
___nightmares	___sleep walking	___tiredness/fatigue	___broken bones
___poor appetite	___stomach problems	___weight loss	___obesity
___thumb sucking	___nail biting	___ menstrual problems	

Other medical issues:_____

FAMILY HISTORY

Name & age of mother, father, and step-parents: _____

_____

_____

Siblings (names, date of birth, full/half or step): _____

_____

_____

Who lives in the home now? _____

Mother's work schedule_____

Father's work schedule _____

Is there any history of emotional problems, depression, alcoholism, substance abuse, suicide, or academic problems in the child's biological family? ____No ____Yes If yes, who and what:

_____

_____

Do any of your other children have behavioral, emotional or learning problems? ____Yes _____No.
If yes, please describe: _____

_____

If the parents are divorced, when did this occur? _____
What are the custody and visitation agreements? _____

_____.

If the parents are divorced, do both parents know about and agree to the child's participation in therapy? _____ Yes _____ No.

DEVELOPMENTAL HISTORY

Were there any problems during the pregnancy? ____Yes ___No

Was there any use of drugs or alcohol during the pregnancy?____Yes ____No

Was the delivery difficult? ____Yes ___No

What age did your child do the following:

Walk alone _____ Dress themselves _____
Complete toilet training _____ Stop wetting the bed _____
Speak single word _____ Speak phrases _____

Are there any other developmental concerns/issues you would like us to know about?

I, the legal parent/guardian of the child or adolescent agree that the information provided on this form is correct to the best of my knowledge.
Signature _____

Zumbro Valley Mental Health Center Psychiatric Services PHQ Addendum

Name: ID:
Today's Date:
Name of person completing questionnaire if not self:
Home phone #: Work phone #:
May we call you at work?
Who referred you to ZVMHC?

Medical History:
Please circle and medical problems you are currently experiencing:

Seizures Cold Sores Sexually Transmitted Disease

Liver Problems Herpes Simples HIV risk factors

Thyroid Problems Skin Disease/disorder Sexual Difficulties

Cancer Heart disease High Cholesterol Acne

Stroke Kidney Disease Asthma Polycystic Ovarian Disease

Atopic Dermatitis Arthritis Diabetes Glaucoma

Lung Disease Heartburn Ulcer Bladder Problems

Headache Osteoporosis Tuberculosis

Irregular Periods Other Male/Female Disease Fibromyalgia

Allergies to Medicine (list): _____

Other Problems (List): _____

List **all medications** you are currently taking **including over the counter and herbal treatments** (medication, dose, reason used, prescribing doctor):

Any additional information you would like to provide:

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____