Today' s date:_____ Date of Assessment:_____ Clinical ID:_____

Zumbro Valley Psychological Services

Child and Adolescent Personal History Questionnaire (PHQ)

Client Name: _____ Birth Date:_____ Age:_____ Sex:_____

Form completed by:_____ Referral Source:_____

Child/ Adolescent's legal guardian(s):

_____

Are there any custody or visitation agreements? If yes, please explain:

_____

Presenting problem(s)/ Reason for Assessment:
Please provide examples of behaviors that you are concerned about.

_____

_____

When did the problems begin?

_____

_____

What have you already done to help with the problems?

_____

_____

Are there, or have there been, other professionals involved in the client's care?

- ☐ Social Worker
- ☐ Skills Worker
- ☐ School social worker
- ☐ Psychologist/ Therapist
- ☐ School Psychologist
- ☐ Youth Behavioral Health
- ☐ In-home Therapist
- ☐ Pediatrician
- ☐ Probation Officer
- ☐ Medical specialist
- ☐ Child Protection
- ☐ School Counselor
- ☐ Foster Parents
- ☐ Mentor
- ☐ Other _____

If yes, please describe what services were provided or offered:_____

_____

Please check the symptoms the client is currently experiencing:

- [ ] Aches/pains
- [ ] Anxious/nervous
- [ ] Ashamed
- [ ] Blames others
- [ ] Body image concerns
- [ ] Can't enjoy myself
- [ ] Choking feeling
- [ ] Cry easily/often
- [ ] Depressed/sad
- [ ] Destroys property/fires
- [ ] Difficulty breathing
- [ ] Distressing memories
- [ ] Disturbing thoughts
- [ ] Dizziness
- [ ] Eating/appetite concerns
- [ ] Elevated mood
- [ ] Excessive worry
- [ ] Feel inferior
- [ ] Feel unworthy
- [ ] Feeling paranoid/suspicious
- [ ] Forgetful
- [ ] Frequent mood swings
- [ ] Frustration
- [ ] Guilt feelings
- [ ] Headaches
- [ ] Hear voices
- [ ] Heart racing
- [ ] Heavy feeling
- [ ] Hoarding
- [ ] Hopelessness
- [ ] Hyperactivity
- [ ] Impulsive
- [ ] Irritable/angry
- [ ] Lack of motivation
- [ ] Lies/steals
- [ ] Loneliness
- [ ] Lose temper
- [ ] Low energy/tired
- [ ] Low self-esteem
- [ ] Motor or verbal tics
- [ ] Nightmares
- [ ] Numbness/tingling
- [ ] Physical aggression/cruelty animals
- [ ] Poor concentration
- [ ] Poor memory
- [ ] Racing thoughts
- [ ] Repetitive actions
- [ ] Restless/fidgety
- [ ] See images or objects
- [ ] Self harming behaviors/urges
- [ ] Sexual issues/concerns
- [ ] Shaking
- [ ] Sleep problems
- [ ] Social discomfort
- [ ] Tense feelings
- [ ] Thoughts of wanting to die
- [ ] Thoughts of wanting to hurt others
- [ ] Wound up

What areas have been impaired by the symptoms listed above:

- [ ] Coping skills
- [ ] Daily living skills
- [ ] Economic/financial impairment
- [ ] Educational/school function
- [ ] Health
- [ ] Housing/shelter
- [ ] Legal difficulties
- [ ] Marital/family conflict or dysfunction
- [ ] Occupational functioning
- [ ] Self protection/personal safety
- [ ] Sexual functioning
- [ ] Socialization

Other:_____

Chemical Use History (Dim 1)

Has the client ever used tobacco? If yes, please describe the use:

Does the client drink alcohol or use drugs? What was the age of first use?

What is typically use and how much?

Has anyone been concerned by the client's chemical use?

Have there been any negative consequences or treatment involvement?

Has gambling ever been a concern and/ or caused problems **(Dim 5)**?

Please describe the family history of addictions or chemical dependency **(Assessment Component)**:

Medical History (Dim 2)

Who is the healthcare provider? When was the last physical exam?

Describe any current medical problems or physical symptoms the client is having:

List any medications the client is taking (Please include dosages and reason for use if known)

Please list any important medical information (illnesses, injuries, surgeries, drug side effects)

Does the client have any allergies?

Has the client been hit in the head, or suffered head or brain trauma or injury?

Mental health History (Dim 3)

Has the client had thoughts or actions of suicide or self-harm? Or harming another person?

List the client's strengths and vulnerabilities **(Assessment Component)**:

Triggers and warning signs for relapse **(Dim 5)**:

Please list previous mental health services (include therapy, psychiatry, hospitalizations, commitments, county services, etc)

Dates of service:	Where was the client seen/treated:	Focus of treatment:

List current and previous medications that have been prescribed for mental health or psychiatric reasons (Please include dosages and reason for use if known)

Social/ Relationship History (Dim 6)

Has the client begun to date? If applicable, how old was the client?

Have these relationships been healthy, or has there been any maltreatment and/ or abuse?

Is the client sexually active? Yes or No

Does the client have children? If yes, please provide name and age(s).

Describe the client's interests: (Include time with friends, hobbies, sports, etc)

Are there spiritual or cultural considerations you would like us to be aware of **(Assessment Component)**?

Coping skills **(Dim 3)**:

Education/ Work History (Dim 6)

What school does the client attend? _____ Current grade:_____

Describe the client's school experience:

(Please be specific and include how many schools the client has attended, academic progress, social involvement, extra-curricular involvement, getting along with teachers and peers, etc)

Have there been any difficulties in school? (please include in/out of school suspensions, expulsions, Truancy, or other academic issues)

Does the client have an Individualized Education Plan (IEP)?

If yes, please describe the special needs and services provided. Please bring a copy.

Is there a family history of family academic problems or concerns? If yes, please describe.

Has the client had any kind of employment? If so, when and where:

Legal History (Dim 6)

Does the client have any past or current legal problems?

If yes, for what? Please provide name of Probation Officer if applicable

Has the client been ordered by court/ probation for assessment, to attend therapy or treatment?

Family History (Assessment Component)

Where was the client born and where has he/she lived since?

What has growing up been like for the client?

Has the client been exposed to violence in the family or elsewhere (verbal, emotional, sexual, physical)?

Has the client been abused, neglected, or maltreated by anyone? If yes, please explain what happened **(Assessment Component)**:

Please complete the following information about significant care givers the client has lived with:
(Include parents, step, grand, or foster-parents, etc)

Name/ Relationship	Age	Occupation	Alive Yes/ No

If the parents were divorced, how old was the client at the time? _____

Please complete the following information about sibling, step-siblings, or half siblings:

Name	Age	Occupation, if applicable	Alive Yes/ No

Who currently lives in the home with the client **(Assessment Component)**?

Please describe the current relationships with the parents/ caregivers /siblings **(Dim 6)**:

Have any family members been treated for or diagnosed with a mental illness **(Assessment Component)**? Please explain.

Has the client known anyone that committed suicide?

Are you aware of any developmental problems or concerns from pregnancy/birth/ childhood/ adolescence? Was there the potential for maternal chemical use during pregnancy **(Assessment Component)**?

At about what age did the client complete the following? (Mark NA if not yet obtained) **(Assessment Component)**

Walk alone:	Complete toilet training:	Speak in sentences:
Sleep through the night:	Discontinue bed wetting:	Other:

Have there been any concerns about the client meeting these developmental milestones or any others?

Coordination of care

Please list any other service providers that are assisting the client:

_____

_____

Please give any additional information that may be important or beneficial in treating the client:

_____

_____

What do you enjoy most about the client? Or as the client, what makes you a special and unique person? _____

_____