Youth History Questionnaire

The following information is used to best determine a treatment plan. Completing this form as fully and accurately as possible will help facilitate this process. Please write all answers legibly. If you need additional space for any of your answers, please use space at the end of this form. If you feel uncomfortable revealing some of the requested information, feel free to put an "X" through those sections.

Personal Data

Name: ____ Date of Birth: _______________

Age: _________ Gender (M/F): _________ SS#: ____

Where were you born? ____

What number child are you? (e.g. 2nd oldest): ______________________________________

How long have you lived in the city you live in currently? _________________________________

Who do you live with? (list names and relationship to you) __________________________________

____

Family History

FATHER

Name: ____ Age: ____________________

Occupation: ____

Health: ____

Briefly describe how you see your father's personality and your relationship with him: ______________

____

____

MOTHER

Name: ____ Age: ____________________

Occupation: ____

Health: ____

Briefly describe how you see your mother's personality and your relationship with her: _______________

____

____

SIBLINGS

Provide names and ages: ____

____

____

____

Briefly describe your relationship with your siblings: ____

____

____

Briefly describe your home atmosphere (compatibility with parents, between parents and children, and between siblings): ____

____

____

Were you adopted? _______ If yes, at what age? _______ If yes, do you know anything about your biological parents? ____

____

Are your parents divorced ? _______ If yes, what age were you when this occurred? __________________

If you have a step-parent or step-parents, give your age when your parent(s) remarried: ________________

Are there any fearful or distressing experiences regarding your family life which stands out in your mind which were not previously mentioned? ____

____

Do you have people outside of your biological family that you feel are "like family" and in whom you can confide? ____

____

Briefly describe your cultural identity?____

Briefly describe your religious or spiritual identity?______________________________________

Educational

What school do you attend? ____

What grade are you in? _________ How are your grades? ___________________________________

Are you currently attending school regularly? ____

Do you have a job? ______ If yes, where? ____

Medical History

List any current medical conditions you are aware of: _____________________________________

____

List all psychiatric medication you are currently taking, including dosages and the dates of the initial prescriptions, and the prescribing physician:

Medication	Dosage	Rx Date	Prescriber

List any psychiatric medications you have taken in the past: ________________________________

____

Do you regularly take any over-the-counter medications other than vitamins (please list)? ______________

____

Primary Care Physician: ____________________________________ Phone #:________________________

Address: ____

When was your last complete physical exam: ____

Are you aware of any significant information about your birth or development? ______________________

____

Mental Health History

Have you ever received counseling before? _______ If yes, please list:

Dates of Care	Provider	Purpose	Outcome

Have you ever been hospitalized for a psychiatric/emotional reason: _______ If yes, please provide the following:

Dates	Hospital	Reason	Outcome

Have you ever thought about or attempted to harm yourself to any degree? ______ If yes, please explain:

____

____

Have you ever thought about or inflicted physical violence on another person? ______ If yes, please explain:

____

____

List any family history of mental health problems, and the relation to you: ___________________________

____

Present Concerns

Please briefly describe your reasons for seeking treatment at this time: ______________________________

____

____

Please check any of the following feelings or symptoms that apply to you:

__ depressed
__ feel inferior
__ hopelessness
__ crying spells
__ mood swings
__ poor concentration
__ poor memory
__ low energy
__ anxious
__ specific fears
__ sleep problems
__ sleeping more than usual
__ relationship problems
__Truancy
__Law breaking behaviors
__Nightmares
__ feel detached
__ poor appetite
__ food binging
__ food purging
__ angry or irritable
__ guilt
__ difficulty making decisions
__ unable to relax
__ unable to enjoy myself
__ lack of interest in previously enjoyed activities
__ memory loss/lapses
__ fearing a loss of control
__ thoughts of harming or killing myself
__Attention Deficit
__Impulsivity

Please describe how you would like your life to be different when you are done with therapy: _______________

____

____

Is there any other information you think I should know prior to our beginning to work together? ______________

____

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