

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: _____ 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:

- | | |
|---|--|
| <input type="checkbox"/> depressed | <input type="checkbox"/> feel detached |
| <input type="checkbox"/> feel inferior | <input type="checkbox"/> poor appetite |
| <input type="checkbox"/> hopelessness | <input type="checkbox"/> food binging |
| <input type="checkbox"/> crying spells | <input type="checkbox"/> food purging |
| <input type="checkbox"/> mood swings | <input type="checkbox"/> angry or irritable |
| <input type="checkbox"/> poor concentration | <input type="checkbox"/> guilt |
| <input type="checkbox"/> poor memory | <input type="checkbox"/> difficulty making decisions |
| <input type="checkbox"/> low energy | <input type="checkbox"/> unable to relax |
| <input type="checkbox"/> anxious | <input type="checkbox"/> unable to enjoy myself |
| <input type="checkbox"/> specific fears | <input type="checkbox"/> lack of interest in previously enjoyed activities |
| <input type="checkbox"/> sleep problems | <input type="checkbox"/> memory loss/lapses |
| <input type="checkbox"/> sleeping more than usual | <input type="checkbox"/> fearing a loss of control |
| <input type="checkbox"/> relationship problems | <input type="checkbox"/> thoughts of harming or killing myself |
| <input type="checkbox"/> Truancy | <input type="checkbox"/> Attention Deficit |
| <input type="checkbox"/> Law breaking behaviors | <input type="checkbox"/> Impulsivity |
| <input type="checkbox"/> Nightmares | |

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? _____
