CHI St. Joseph Children's Health

Personal History Form (Child <18)

Patient Name:		Date: ____/____/_____
Sex: ☐ F ☐ M	Date of Birth:	
Grade:	School District / Building:	
Form Completed By (If other than Patient):		
Address:		
City:	State:	ZIP Code
Phone (Primary): ☐C ☐H ☐W	Phone (Secondary): ☐C ☐H ☐W	

If you need additional space for any of the following questions, please use the back of the sheet.

Primary reason(s) for seeking services:			
☐ Anger Management	☐ Anxiety	☐ Coping	☐ Depression
☐ Eating Issues	☐ Fear/Phobias	☐ Compulsive Behaviors	☐ Sexual Concerns
☐ Sleeping problems	☐ Addictive Behaviors	☐ Alcohol/Drugs	☐ Hyperactivity
☐ Social Difficulties	☐ Learning Difficulties	☐ Trauma	☐ Mood Swings
☐ Thought Problems	☐ Other concerns (specify):		

Family History

With whom does the patient live at this time?	☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other (_____)
Are parents divorced or separated? ☐ No ☐ Yes - Divorced ☐ Yes - Separated	
If Yes, with who has legal custody? ☐ Mother ☐ Father ☐ Other (_____)	
Is there any significant information about the parents' relationship or treatment toward the child that may be of importance in the child's treatment? ☐ Yes ☐ No	
If yes, please describe**:**	

Patient's Mother

Name:		Age:
Occupation:	☐ Fulltime ☐ Part-time ☐ Seasonal	
Employer:		
Education:	☐ Primary School ☐ Middle School ☐ High School Diploma/GED ☐ Associates Degree ☐ Bachelor's ☐ Advanced Degree ☐ Other	
Relationship to the Patient:	☐ Birth Parent ☐ Step-Parent ☐ Adoptive Parent ☐ Foster Parent ☐ Other (_____)	
Is there anything notable/unusual or stressful about the child's relationship with the mother?	☐ Yes ☐ No	
If yes, please specify:		
How is the child disciplined by the mother?		
For what reasons does the mother discipline the child?		

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Patient's Father

Name:		Age:
Occupation:	☐ Fulltime ☐ Part-time ☐ Seasonal	
Employer:		
Education:	☐ Primary School ☐ Middle School ☐ High School Diploma/GED ☐ Associates Degree ☐ College ☐ Advanced Degree ☐ Other	
Relationship to the Patient:	☐ Birth Parent ☐ Step-Parent ☐ Adoptive Parent ☐ Foster Parent ☐ Other (_____)	
Is there anything notable/unusual or stressful about the child's relationship with the father?		☐ Yes ☐ No
If yes, please specify:		
How is the child disciplined by the father?		
For what reasons does the father discipline the child?		

Patient's Siblings

Name	Age	Sex	Lives	Quality of relationship w/ Patient
		☐ F ☐ M	☐ @home ☐ away	☐poor ☐ avg. ☐good
		☐ F ☐ M	☐ @home ☐ away	☐poor ☐ avg. ☐good
		☐ F ☐ M	☐ @home ☐ away	☐poor ☐ avg. ☐good
		☐ F ☐ M	☐ @home ☐ away	☐poor ☐ avg. ☐good
		☐ F ☐ M	☐ @home ☐ away	☐poor ☐ avg. ☐good

Others in the Household

Name	Age	Sex	Relationship (cousin, foster child, grandparent)	Quality of relationship w/ Patient
		☐ F ☐ M		☐poor ☐ avg. ☐good
		☐ F ☐ M		☐poor ☐ avg. ☐good
		☐ F ☐ M		☐poor ☐ avg. ☐good
		☐ F ☐ M		☐poor ☐ avg. ☐good
		☐ F ☐ M		☐poor ☐ avg. ☐good

Comments: _____

Family Health History

Please indicate if any of the following diseases have occurred among the child's blood relatives (parents, siblings, aunts, uncles, grandparents, etc.). Check all that apply:

☐ Allergies	☐ Cleft Lip	☐ Mental Illness	☐ Spinal Bifida
☐ Anemia	☐ Deafness	☐ Migraines	☐ Suicide
☐ Asthma	☐ Diabetes	☐ Multiple Sclerosis	☐ _____
☐ Bleeding Tendency	☐ Thyroid Disease	☐ Muscular Dystrophy	☐ _____
☐ Early Sudden Cardiac Death	☐ Heart Disease	☐ Nervousness	☐ _____
☐Cancer	☐ High Blood Pressure	☐ Learning Difficulties	☐ _____
☐ Cerebral Palsy	☐ Kidney Disease	☐ Seizures	

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Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? ☐ Yes ☐ No

If yes, please describe: _____

Was the pregnancy planned? ☐ Yes ☐ No Length of pregnancy: _____

Did mother receive prenatal care? ☐ Yes ☐ No

Mother's age at birth of child: _____ Father's age at birth of child: _____

Birth Order: Child is ____ of ____ children in the family.

How many pounds did the mother gain during the pregnancy? _____

Did the mother smoke during pregnancy? ☐ Yes ☐ No If yes, what amount: _____

Did the mother use drugs or alcohol during pregnancy? ☐ Yes ☐ No

If yes, type/amount: _____

While pregnant, did the mother experience any medical or emotional difficulties (i.e. surgeries, hypertension, medications, significant levels of emotional stress) ☐ Yes ☐ No

If yes, please describe: _____

_____

Length of Labor: _____ Induced: ☐ Yes ☐ No Caesarean: ☐ Yes ☐ No

Baby's birth weight: _____ Baby's birth length: _____

Did the baby require time in a Special Care Nursery? ☐ Yes ☐ No

Infancy/Toddlerhood (Check all that apply)

☐ Breast fed	☐ Milk allergies	☐ Vomiting	☐ Diarrhea
☐ Bottle fed	☐ Rashes	☐ Colic	☐ Constipation
☐ Not cuddly	☐ Cried often	☐ Rarely cried	☐ Overactive
☐ Resisted solid food	☐ Trouble sleeping	☐ Irritable when awakened	☐ Lethargic

Development History (Please note the age at which the following behaviors took place)

Sat Alone:	Took 1st Steps:	Spoke Words:	Dressed Self:	Spoke Sentences:
Weaned:	Toilet Trained:	Dry During Day:	Dry during Night:	Fed Self:
Tied Shoes:	Rode two-wheeled bike:			

Compared with others in the family, child's development was: ☐ Slow ☐ Average ☐ Fast

Please indicate the age for the following developments (if applicable):

Began puberty:	Menstruation:
Voice Change:	Injuries or hospitalization:
Breast Development:	

Issues that affected child development (i.e. physical/sexual abuse, nutrition, neglect, etc.): _____

_____

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During the child's first 5 years of life, were there any significant stressors within the family? ☐ Yes ☐ No

If yes, please describe: _____

_____

Education

Current School:			School Phone:	
Type of School: ☐ Public ☐ Private ☐ Charter ☐ Cyber ☐ Other (_____)				
Grade:	Teacher:		School Counselor:	
Special education: ☐ Yes ☐ No	If Yes, describe:			
Gifted Program: ☐ Yes ☐ No	If Yes, describe:			
Has child ever been held back? ☐ Yes ☐ No				
If yes, describe:				
What subjects does the child enjoy in school?				
What subjects does the child dislike in school?				
What grades does the child usually receive?				
Have there been any recent changes in the child's grades? ☐ Yes ☐ No				
If Yes, describe:				
Has child ever been tested psychologically ☐ Yes ☐ No				
If Yes, please describe:				
Check the descriptions that specifically relate to your child:				
Feelings about School Work				
☐ Anxious	☐ Passive		☐ Enthusiastic	
☐ Fearful	☐ Eager		☐ No expression	
☐ Bored	☐ Rebellious		☐ Other:	
Approach to School Work				
☐ Organized	☐ Industrious		☐ Responsible	
☐ Interested	☐ Self-directed		☐ No initiative	
☐ Refuses	☐ Does only what is expected		☐ Sloppy	
☐ Disorganized	☐ Cooperative		☐ Doesn't complete assignments	
☐ Other:				
Performance in School (Parent's Opinion)				
☐ Satisfactory	☐ Underachieving		☐ Overachieving	
☐ Other:				
Child's Peer Relationships				
☐ Difficulty making friends	☐ Makes friends easily		☐ Follower	
☐ Leader	☐ Long-time Friends		☐ Spontaneous	
☐ Shares easily	☐ Other (describe):			
Who is responsible for your child in the following areas:				
School	☐ Mother	☐ Father	☐ Shared	Other:
Health	☐ Mother	☐ Father	☐ Shared	Other:
Problem Behavior	☐ Mother	☐ Father	☐ Shared	Other:

Employment (Child/Patient)

If your child works a job or is involved in a vocational program, please complete the following:

What is your child's attitude toward work?	☐ Poor	☐ Average	☐Good	☐ Excellent
Current Employer:				
Position:	Hours Worked per Week:			
Have your child's grades been affected since working:	☐ Lower	☐ Same	☐ Higher	
How many previous jobs has your child had?				
Usual length of employment:	Usual reason for leaving:			

Leisure/Recreation

Describe special areas of interest or hobbies (art, crafts, sports, outdoor activities, church activities, etc.)

Activity	Presently, how often does the child engage in the activity?	In the past, how often did the child engage in the activity?

What are the family's favorite activities? _____

_____

_____

What does your child/adolescent do with unstructured time? _____

_____

_____

Has your child/adolescent experienced death (friend, family member, pet, other)? ☐ Yes ☐ No

If yes, at what age? _____

If yes, please describe your child's/adolescent's reaction: _____

_____

Have there been any other significant changes **or potentially traumatic** events in your child's life (family, moving, fire, etc.)?

☐ Yes ☐ No If yes, please describe: _____

_____

_____

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Medical and Physical Health

Please indicate if your child has had or does currently have any of the following:

☐ Abortion	☐ Hepatitis	☐ Rheumatic Fever
☐ Asthma	☐ HIV / AIDS	☐ Seizures
☐ Blackouts/Lightheadedness	☐ Lead Poisoning	☐ Severe Infections
☐ Cerebral Palsy	☐ Lyme Disease	☐ Severe Head Injury
☐ Concussions	☐ Meningitis	☐ Sexually Transmitted Infection
☐ Congenital Problems	☐ Miscarriage	☐ Staring Spells
☐ Diabetes	☐ Multiple Sclerosis	☐ Thyroid Disorder
☐ Diphtheria	☐ Muscular Dystrophy	☐ Vision Problems
☐ Dizziness	☐ Nose Bleeds	☐ Wears glasses/contacts
☐ Ear Infections	☐ Other Skin Rashes	☐ Other:
☐ Eczema	☐ Paralysis	☐ Other:
☐ Encephalitis	☐ Pregnancy	☐ Other:
☐ Heart Problems		
List any current health concerns:		
List any recent health or physical changes:		

Nutrition

Meal	**How Often** (Times per week)	**Types of Foods Eaten**	**Avg. Amount of Food Consumed**
Breakfast	___/Week		☐ None ☐ Low ☐ Med ☐ High
Lunch	___/Week		☐ None ☐ Low ☐ Med ☐ High
Dinner	___/Week		☐ None ☐ Low ☐ Med ☐ High
Snacks	___/Week		☐ None ☐ Low ☐ Med ☐ High
Comments:			

Most Recent Examinations

Type of exam	**Date of Most Recent Visit**	**Results/Findings**
Physical Exam (Medical)		
Dental Exam		
Vision Exam		
Hearing Exam		
Other:		

Current Prescribed Medications

Medication	Dose	Purpose	Side Effects

Current Over-the-Counter Medications

Medication	Dose	Purpose	Side Effects

Immunizations

Has your child received all recommendation immunizations? ☐ Yes ☐ No

If no, why has your child not been immunized? _____

Chemical Use History

Does your child/adolescent use or have a problem with alcohol or drugs? ☐ Yes ☐ No

If yes, please describe: _____

_____

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Counseling / Behavioral Health Treatment History

Please answer the below questions about your child's past and present experience with counseling, behavioral health and psychiatric care.

Type of treatment/service	Yes / No	When	Where	Reaction or Overall Experience
Counseling / Psychiatric Treatment	☐ Yes ☐ No			
Suicidal Thoughts / Attempts	☐ Yes ☐ No			
Drug/Alcohol Treatment	☐ Yes ☐ No			
Hospitalization	☐ Yes ☐ No			

Behavioral / Emotional History

Please check any of the following that describe your child:

☐ Affectionate	☐Frustrated easily	☐ Sad
☐ Aggressive	☐ Gambling	☐ Selfish
☐ Alcohol problems	☐ Generous	☐ Separation anxiety
☐ Angry	☐ Hallucinations	☐ Sets fires
☐ Anxious	☐ Head banging	☐ Sexual addiction
☐ Avoids adults	☐ Heart problems	☐ Sexual acting out
☐ Bedwetting	☐ Hopelessness	☐ Shares
☐ Blinking, jerking	☐ Hurts animals	☐ Sick often
☐ Bizarre behavior	☐ Imaginary friends	☐ Short attention span
☐ Bullies, threatens	☐ Impulsive	☐ Shy, timid
☐ Careless, reckless	☐ Irritable	☐ Sleeping problems
☐ Chest pains	☐ Lazy	☐ Socially Awkward
☐ Clumsy	☐ Learning problems	☐ Soiling
☐ Confident	☐ Lies frequently	☐ Speech problems
☐ Cooperative	☐ Listens to reason	☐ Steals
☐ Cyber addiction	☐ Loner	☐ Stomach aches
☐ Defiant	☐ Low self-esteem	☐ Suicidal threats
☐ Depression	☐ Moody	☐ Suicidal attempts
☐ Destructive	☐ Negative Thinking	☐ Talks back
☐ Difficulty speaking	☐ Nightmares	☐ Teeth grinding
☐ Dizziness	☐ Obedient	☐ Thumb sucking
☐ Drug dependence	☐ Oppositional	☐ Tics or twitching
☐ Eating disorder	☐ Over active	☐ Unsafe behaviors
☐ Enthusiastic	☐ Over weight	☐ Unusual thinking
☐ Excessive masturbation	☐ Panic attacks	☐ Weight loss
☐ Expect failure	☐ Phobias	☐ Withdrawn
☐ Fatigue	☐ Poor appetite	☐ Other:
☐ Fearful	☐ Quarrels	☐ Other:
☐ Frequent injuries	☐ Repetitive Behaviors	☐ Other:

Please describe any of the above (or other concerns): _____

_____

_____

_____

How have problems/concerns generally been addressed? _____

_____

Any additional information that would assist in understanding your child/adolescent?

_____

_____

_____

Any additional information that would assist in understanding the current concerns/problems?

_____

_____

_____

What are your goals for the child's treatment? _____

_____

Do you believe that your child is suicidal at this time? ☐ Yes ☐ No

If yes, please explain: _____

_____

Completed By: _____ Date: _____

Relationship to Child: _____

**********For Staff Use**********

Therapist/Psychiatrist/Nurse Practitioner Comments:

_____

_____

_____

_____

_____

_____

_____

Staff Signature and Credentials: _____ Date: _____