Park Ridge Psychological Services

History and Questionnaire

Please complete this form as accurately and as fully as possible.

Client Information

Patient's Name:_____ Date of Birth:_____ Age:_____ Gender:_____

Occupation/School:_____ Grade:_____ Marital Status:_____

Home Address:_____

Home Phone: (_____)_____Cell#: (_____)_____ Work#: (_____)_____

Responsible Party (if not client)

Name:_____ Occupation:_____

Marital Status:_____ Emergency Contact:_____ Phone: (_____)_____

Who referred you to Park Ridge Psychological Services?_____

Why have you come to us at this time/What do you hope to accomplish from your time here?

_____

_____

_____

Have you attempted to solve these problems before? If so, when and how?_____

_____

What about past attempts at solving the problem(s) was not helpful? _____

_____

Family Constellation

Who lives at home with the client? (please include extended family and pets)

Name:_____ Relationship:_____ Age:_____

Describe the relationship between this person and the client:_____

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Describe the relationship between this person and the client:_____

Who else in the client's family is important to him/her?_____

Are there any conflictual relationships in the home? If so, please describe:_____

_____

Please describe the marriage of the client's parents:_____

_____

Please describe any important family events (e.g., divorces, remarriages, deaths, traumas, losses, significant moves, etc.):_____

_____

_____

Natural Mother's History:

Age:_____ Career/Profession:_____ Education:_____

Any history of drug/alcohol use/abuse:_____ If yes, please describe:_____

Any history of learning/attention problems?_____

Any medical problems?_____ Any evaluation or treatment for emotional problems?_____

Please describe briefly mother's family of origin, including significant conflict, history of emotional/learning problems:_____

_____

_____

Natural Father's History:

Age:_____ Career/Profession:_____ Education:_____

Any history of drug/alcohol use/abuse:_____ If yes, please describe:_____

Any history of learning/attention problems?_____

Any medical problems?_____ Any evaluation or treatment for emotional problems?_____

Please describe briefly father's family of origin, including significant conflict, history of emotional/learning problems:_____

_____

_____

Step-Parent or other parental figure History:

Age:_____ Career/Profession:_____ Education:_____

Any history of drug/alcohol use/abuse:_____ If yes, please describe:_____

Any history of learning/attention problems?_____

Any medical problems?_____ Any evaluation or treatment for emotional problems?_____

Please describe briefly person's family of origin, including significant conflict, history of emotional/learning problems:_____

_____

_____

Was family a source of closeness, intimacy, emotional safety when growing up or was it more distant or high conflict?

_____

_____

_____

Developmental History

Parents' attitude toward pregnancy:_____ Ease of conception:_____

Complications of pregnancy/birth:_____

Post delivery blues or postpartum depression?_____ If so, for how long?_____

Diet/Sleep History: Breast vs. bottle_____ Age weaned_____ Food allergies_____

Early sleep behavior: Sleepwalking, night terrors, dysregulation, etc. _____

Toilet training: Age reached bowel control: day_____ night_____ Bladder control: day_____ night_____

Ease/difficulty with training_____ Current function:_____

Sexual development: Any concerns regarding gender identity?_____

Any suspected history of sexual acting out and/or sexual abuse?_____

Motor development: How is his/her fine motor coordination?_____Gross motor coordination:_____

Language Development: When did the client: Say several words, besides mama, dada_____ Name several objects_____

Put 3 words together (subject, verb, object)_____ How would you describe the client's: Vocabulary:_____

Articulation:_____ Comprehension:_____ Oral reading fluency:_____

Sensory Processing: Any areas of sensory processing (auditory, visual, tactile) that seem hypersensitive or undersensitive? _____

_____

Social Development: How was the client's attachment with mother growing up?_____

Was there a time attachment changed?_____

How was the client's attachment to father? _____

Was there a time attachment changed?_____

How is the client's ability to make, maintain good friendships?_____

Does the client have any significant hobbies or interests?_____

How would you describe the client's current relationships with same-sex peers?_____

How are his/her relationships with opposite sex peers?_____

Behavior/Discipline: How compliant was/is the client as a child?_____ What methods of discipline do/did parents use to shape the client's behavior?_____

Which methods were most successful/least successful:_____

Any history of physical abuse?_____

Do parents/guardians have similar/united discipline methods/philosophy? _____

Emotional Development: How would you describe the client's temperament as a baby (e.g., colicky, happy, content, excitable, curious, etc.)?_____

Any phobias/fears?_____ Any history of emotional abuse?_____

Drug/Alcohol use/abuse: Please list all usage:_____

_____

School History: Current grade:_____ Current School:_____ Average grades:_____

Homework problems:_____ Specific learning problems:_____

What do/did teachers say about the client?_____

Religious Development: What is the client's religious background? _____ Is his/her religious beliefs important to him/her or to the family? _____

Self-Identity Development: What is the client's ethnic/racial background?_____

Has the client experienced any discrimination due to ethnic/racial background?_____

How would you rate the client's self esteem on a scale from 1-10 (with 10 being the highest):_____

Medical History:

Please explain in detail current and past medical problems/concerns:_____

_____

_____

Current medications (with dosage, reason):_____

_____

Any side effects?_____

Are you happy with the current medication regimen?_____

How is the client's current diet? _____

Does the client exercise regularly? (If no, are there any limitations?)_____

How does the client sleep? (How many hours, is it interrupted, is there snoring, etc.)_____

Who is the client's Primary Care Physician?_____

Etc.

What are the client's personal strengths?_____

_____

What are the major stressors in the client's life? Currently:_____

In the past:_____

What resources does the client have in aiding him/her in getting better?_____

_____

Is there anything else we should know about the client or his/her history or present situation that might help us better evaluate and help the client?_____

_____

_____

Thank you very much for your attention to this history/questionnaire. If you recall anything important after you complete it, please feel free to contact your clinician.