Michigan State University Department of Psychiatry

Personal History

Patient Name: _____

MRN: _____

Psychiatric Assessment Services for Children and Adolescents

Please help us become acquainted with your child & family by the answering the following questions as thoroughly as possible.

Child's Name	Sex □ Male □ Female	Today's Date
Date of Birth	School	School Grade
Home Address	Child's Physician	How did you hear of our clinic? □ Physician □ Therapist □School □ Insurance □ Other _____
Telephone □Home □ Cell	Physician Address & Phone	
Your Name	Relationship to Patient □ Father □ Mother □ Guardian □ Grandparent	

BACKGROUND INFORMATION-

Chief Complaint -- Please provide a brief description of your concerns and/or the reason for your visit:

Does your child or has your child difficulty with any of the following? Check all that apply.

__ Sleep problems
__ Eating problems
__ Sadness/crying
__ Anger/irritability
__ Tantrums/rages
__ Feeling hopeless/guilty
__ Unable to enjoy activities
__ Harm to self
__ Harm to others or property
__ Inflated self confidence
__ Episodic increases in energy
__ Excessive worries or fears
__ Nervous habits
__ Repetitive thoughts or actions
__ Panic attacks
__ History of traumatic event(s)
__ Problems with friends
__ Problems in classroom
__ Frequent physical complaints
__ Attention/concentration
__ Repetitive movements or sounds
__ Defiance
__ School avoidance or truancy
__ Bullying others or being bullied
__ Tobacco, alcohol, or drug use
__ Lying or theft
__ Excess concerns about weight
__ Bizarre ideas or experiences
__ Hallucinations
__ Special idiosyncrasies
__ Sensory issues
__ Delays in development
__ Bedwetting or toileting issues
__ Nightmares
__ Snoring
__ Speech problems

Has your child ever been prescribed medications for this problem or mental health reasons? ___ Yes ___ No
If yes, please complete the following:

Name of Medication	Dates Taken	Prescribed by	Reason	Outcome

Has your child been seen by a counselor/therapist in the past? ___ Yes ___ No
If yes, please complete the following:

Name	Dates Seen	Reason Seen	Type of Therapy

Has your child been seen by a psychiatrist in the past? ___ Yes ___ No
If yes, please complete the following:

Name	Dates Seen	Reasons and/or Diagnoses?

Has your child ever been psychiatrically hospitalized? ___ Yes ___ No
If yes, please complete the following:

Name	Dates	Reasons and/or Diagnoses?

Does your child drink caffeine (tea, pop, coffee, energy drinks, etc.)?

_____Yes _____No If so, how much? _____

Do you have any concerns about your child using drugs and/or alcohol? _____Yes _____ No
If yes, please explain: _____

Do you have guns or other weapons in your home? _____ Yes _____No

MEDICAL HISTORY-

Vaccinations up to date? _____Yes _____ No _____ Unsure

When was the last time your child was seen by their doctor? _____ Reason? _____

Does your child have any other health problems? _____ Yes _____ No

If yes, please list: _____

Please circle if your child has had any of the following: Chicken Pox Scarlet Fever Meningitis Measles

Tuberculosis Rheumatic Fever Whooping Cough Encephalitis Mumps Roseola Polio

Has your child ever experienced any of the following: Hospitalization _____Yes _____ No

Accidents _____ Yes _____ No Surgery _____Yes _____ No

Head Injuries _____ Yes _____ No Heart Problems _____Yes _____ No

Seizures _____Yes _____ No

If yes, please describe:_____

_____

Is your child allergic to any medication (s)? _____Yes _____ No

If yes, please list:_____

Does your child take any vitamins, minerals, prescription, or other non-prescription medication (s)?
_____Yes _____ No

If yes, please list:

Medication	Dose	How Often	Reason

DEVELOPMENTAL HISTORY-

PREGNANCY- Normal Pregnancy? _____Yes _____ No
If problems, please describe: _____

During pregnancy, did mother use any of the following? If yes, please provide details regarding use, timing, amount, etc.

Medications ___Yes ____No _____ Alcohol _____Yes ___ No _____

Tobacco_____ Yes___ No _____ Illicit Drugs_____Yes ___No _____

LABOR & DELIVERY- Full term? _____Yes ___ No If no,_____Premature _____Overdue By how many weeks?_____

Labor _____ Easy _____Difficult How many hours? _____ Baby's presentations? _____ Headfirst _____ Breech

Delivery? _____ Vaginal _____ C-section Induced?_____Yes _____ No Birth Weight _____lbs. _____oz

If delivered by C-section, why? _____
Following delivery, did your child…. (please check all that apply)

__need supplemental oxygen __show any signs of birth trauma __need any x-ray, CT, or MRI
__need any blood transfusions __have any other complications

NEWBORN PERIOD- Did your child exhibit any of the following:

	How Long?		How Long?
__ Irritability	_____	__ Breastfeeding	_____
__ Vomiting	_____	__ Normal Weight Gain	_____
__ Difficulty Breathing	_____	__ Convulsions/Seizures	_____

DEVELOPMENT- Any concerns your child was delayed in development? _____Yes _____ No
If yes, please circle area(s) of concern: Motor/ Language/ Social

	Age		Age		Age
Sitting without help		Spoke single words		Weaned	
Crawling		Spoke in sentences		Bladder Trained	
Walking		Puberty		Bowel Trained	

In relationship to siblings and peers? __ Plays individually __ Plays in groups __ Competitive
__ Cooperative __ Leader __ Follower

EDUCATION- Types of classes: __ Regular Education __ Resource Room __ Alternative Education
__ Home Schooling __ Special Education __ Learning Disabled
__ Emotionally Impaired __ 504 Plan __ Other
Please describe any additional interventions including school accommodations, tutoring:

_____

Has your child had specific learning difficulties? ___ Yes ___ No
Has your child undergone testing to evaluate? ___ Yes ___ No
If yes, please describe in detail and bring a copy of any testing results to your visit: _____
Has your child skipped a grade? ___ Yes ___ No Repeated a grade? ___ Yes ___ No
If yes to either, describe_____
Name/Title/Phone number of persons at school familiar with your child's behavior and academic performance:

_____

	Name of School	City	Date Began	Date Ended	Grades Completed Here
Preschool					
Elementary					
Middle School					
High School					

Please complete the following for your current family situation. Additional lines available for stepparent, grandparents, etc.

Relation	Name	Age	DOB	Birthplace	Education	Occupation
Mother						
Father						

Parents: ___ Married ___ Separated ___ Divorced If remarried or previously married, please provide dates:

Dates: _____ _____ _____ Mother _____Father _____

If parents are not currently together, what is the custody agreement? _____

Deceased _____Mother/Father Date/Circumstances _____

Siblings—Please complete the following chart for all siblings:

Name	Age	Sex	School or Occupation	Grade	Relationship (full, half, step, etc.)	Living at Home	Any Mental Illness?	Uses drugs or alcohol?
		__ M __F				__Y __ N	__Y __ N	__Y __ N
		__ M __F				__Y __ N	__Y __ N	__Y __ N
		__ M __F				__Y __ N	__Y __ N	__Y __ N
		__ M __F				__Y __ N	__Y __ N	__Y __ N
		__ M __F				__Y __ N	__Y __ N	__Y __ N
		__ M __F				__Y __ N	__Y __ N	__Y __ N

Sources of Family income?_____

Sources of Family stress? _____

Living Arrangements—Please list all individuals residing in the home & their relationship to child:

_____ _____

_____ _____

_____ _____

Number of moves _____

Location	Dates	House / Apt / Other	Rent / Own
	to		
	to		
	to		
	to		

Has child ever lived away from family?_____Yes_____ No If yes, explain: _____

Is child adopted? ___ Yes ___ No Adoption Source _____ Age of child at adoption _____

Date adoption legalized_____ What does child know? _____

Are there special reasons/circumstances regarding the adoption? _____

_____

LEGAL HISTORY-

Has patient ever been: __ In trouble with the police __ Charged with a crime __ Arrested
__ Convicted of a crime __ On Probation __ In juvenile detention or jail

If yes to any of the above, describe:_____

_____

FAMILY HISTORY-

Any family history of cardiovascular disease before age 35 including arrhythmia, fainting, sudden death, etc.? __ Yes __No

Please indicate any mental health history in each of the child's biological or blood relatives with an X in the corresponding column:

			Paternal (father's) Family				Maternal (mother's) Family		
	Siblings	Father	Aunts / Uncles	Grand parents	Cousins / Other	Mother	Aunts / Uncles	Grand parents	Cousins / Other
Depression									
Anxiety									
Obsessions or Compulsions									
Mania or Bipolar Disorder									
Psychosis or Schizophrenia									
Attention or Concentration Problems									
Hyperactivity Problems									
Learning Problems									
Mental Retardation									
Alcohol Problems									
Drug Use Problems									
Legal Problems									
Abuse or Neglect									
History of suicide attempts									
History of harming self									
History of harming others									
History of psychiatric hospitalization									
Use of psychiatric medication									

REVIEW OF SYSTEMS- Has your child experienced any of the following? Please mark all that apply.

GENERAL

___ Fever/Chills
___ Weight loss
___ Changes to energy level

CARDIOVASCULAR

___ Chest Pain
___ Fainting
___ Feeling heart beating/racing
___ Blood Pressure problems
___ Heart Murmur

NEUROLOGICAL

___ Vision changes/problems
___ Head injury
___ Trouble walking
___ Seizures
___ Headaches
___ Numbness/Tingling
___ Clumsiness/balance problems

PULMONOLOGY

___ Wheezing or Asthma
___ Trouble breathing while at rest

HEAD,EYES,EARS,NOSE & THROAT

___ Glasses
___ Hearing Problems
___ Ear Infections/ Ear Pain
___ Seasonal/Environmental Allergies
___ Strep Throat
___ Sinus Problems

ENDOCRINOLOGY

___ Intolerance to heat/cold
___ Unusual weight changes
___ Blood sugar problems
___ History of Diabetes

HEMATOLOGY

___ Bleeding Problems
___ Abnormal bruising

GASTROENTEROLOGY

___ Frequent stomachaches
___ Nausea/vomiting
___ Diarrhea

URINARY

___ Trouble Urinating
___ Bladder/Kidney Infections
___ Nighttime Incontinence

MUSCULOSKELETAL

___ Joint Pain/Swelling
___ Growing Pains
___ Muscle Weakness

SKIN

___ Rashes
___ Picking
___ Large/Unusual Birthmarks