Psychosocial History

**Patient Information (Child)**

First Name: Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Pay \_\_\_\_\_\_\_\_\_\_

Mother \_\_ or Guardian \_\_

Name:

Address:

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:

Father\_\_ or Guardian \_\_

Name:

Address:

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:

Members of Household

 Name Relationship Age

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:

Surgical Procedures:

Dietary Restrictions:

Physical Illnesses:

Current Medications:

Has the patient ever been hospitalized for a psychiatric issue:

Pregnancy Complications:

Birth Complications:

Developmental Milestones:

How well does the patient sleep:

Recent changes in eating habits:

**Current Education Level**:

When the patient started school, was there any problems separating from primary care givers:

How many days per month is the patient absent from school:

Is the patient receiving special educations services:

Has the patient been in trouble at school with peers:

Has the patient been in trouble at school with teachers:

Does the patient have difficulties writing, reading or learning arithmetic:

**What are your main concerns about your child**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you notice the problems start:

Has the patient been diagnosed with a mental health diagnosis in the past:

History of Previous Counseling:

Has your child been subject to or witness:

Domestic violence:

Emotional abuse:

Physical abuse:

Sexual abuse:

Separation or Divorce:

Recent Deaths or Losses:

Family History

Does anyone in the household smoke:

Are there any guns in the house:

How many times has the family moved in the past 2 years:

Has a family member ever been incarcerated:

How often does the family eat dinner together:

What does the family do together for fun:

How strong are the family’s religious practices: A. very strong b. moderately strong c. not strong

Does either parent have a history of depression or anxiety:

How much alcohol does members of the household drink (drinks per week):

Does either parent have a history of drug abuse:

Other Family Stressors:

Financial Stressors:

Employment Stressors:

Relationship Stressors:

Health Stressors: