Fishers Youth Counseling and Psychiatry
Psychosocial History

Patient Name: _____ Patient ID: _____ DOB: _____

Family Status

Primary Household

Name	Age	Relationship to patient	Quality of relationship
			Excellent Good Fair Poor
			Excellent Good Fair Poor
			Excellent Good Fair Poor
			Excellent Good Fair Poor
			Excellent Good Fair Poor
			Excellent Good Fair Poor

Secondary Household

Name	Age	Relationship to patient	Quality of relationship
			Excellent Good Fair Poor
			Excellent Good Fair Poor
			Excellent Good Fair Poor
			Excellent Good Fair Poor
			Excellent Good Fair Poor
			Excellent Good Fair Poor

Status of parents: ☐ Married ☐ Separated – when: _____ ☐ Divorced – when: _____
☐ Partnered ☐ Deceased – when: _____ ☐ Never Married

Custody arrangement or visitation information: ☐ not applicable or describe: _____
_____

Mother – Highest educational degree completed: _____
Mother – Occupation / Employer: _____
Father – Highest educational degree completed: _____
Father – Occupation / Employer: _____

Developmental History

Problems with pregnancy / birth: ☐ No ☐ Yes, describe: _____
_____

Problems from infancy to 2 years: ☐ No ☐ Yes, describe (i.e. slow to walk or talk): _____
_____

Problems from 2 to 5 years: ☐ No ☐ Yes, describe (i.e. toilet training, socialization): _____
_____

Problems from 5 to 12 years: ☐ No ☐ Yes, describe (i.e. school adjustment, social skills): _____
_____

Problems in Jr/Sr High School: ☐ No ☐ Yes, describe: _____
_____

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Medical History

Current Primary Care Physician: _____

History of seizures, head trauma or loss of consciousness: ☐ No ☐ Yes, describe: _____

History of medical hospitalizations: ☐ No ☐ Yes, describe: _____

History of chronic conditions (i.e. asthma, diabetes): ☐ No ☐ Yes, describe: _____
_____

Current Medication	Dose	Prescribing Physician	Prescribed for Management of

Allergies: ☐ No ☐ Yes, describe: _____

Mental Health History

Has the patient been previously diagnosed with a mental health condition: ☐ No ☐ Yes, please explain: _____
_____

Past Treatment History

Name of provider / facility	Date(s) seen	Frequency (i.e. weekly, monthly)	Issue Addressed

Has the patient previously been prescribed medication for the management of a mental health condition: ☐ No ☐ Yes, please explain: _____

Family members or relatives who have suffered from mood disorders, depression, anxiety, thought disorders, alcohol / substance abuse (please explain and give details): _____
_____
_____
_____

Legal History ☐ Not Applicable

Charges or Arrests	Date	Outcome

Probation Officer: ☐ No ☐ Yes, Name and contact information: _____
Other legal issues (including important family history): _____
_____

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Educational History

Current grade level / highest educational level completed: _____
Grades repeated: ☐ No ☐ Yes, please explain: _____
Current grade average: _____ Currently performing at ability: ☐ Yes ☐ No, please explain: _____
_____
Current school: _____ Current Teacher: _____
Relationship with teachers: _____
Extracurricular activities: _____
History of: ☐ Learning Disabilities ☐ Psychoeducational testing ☐ Truancy ☐ Disciplinary Actions
Please explain: _____
_____

Social /Leisure / Work History

Please describe how your family spends time together: _____
_____
Describe how the patient spends time with friends: _____
_____
Describe how the patient spends time alone: _____
_____
Describe the patients work history: _____
_____

Spiritual History

Does the patient have a supportive religious or spiritual community: ☐ No ☐ Yes, name / affiliation: _____
_____
Religious/spiritual community is: ☐ very important to caretaker ☐ important to caretaker ☐ not important to caretaker
☐ very important to patient ☐ important to patient ☐ not important to patient

Additional comments: _____
_____

Additional Comments *(please include other information you think is important for us to know):*

_____
_____
_____
_____
_____
_____
_____

_____ _____
Name / Relationship to patient Date