



PERSONAL HISTORY QUESTIONNAIRE – PARENT OF TEEN

Name of Teen _____ DOB _____

Person completing form: _____ Relationship: _____

What are your reasons for seeking counseling?

To what degree does the problem affect your family life? *Mild / moderate / significant / severe*

your teen's friendships? *Mild / moderate / significant / severe*

your teen's functioning at school? *Mild / moderate / significant / severe*

How long have you had these concerns? _____

Specify any previous counseling/treatment:

Check any that apply to your teen:

Angry outbursts	Difficulty being away from home/parent	Kindness	Responsible
Anxious	Dislikes being alone	Lack of motivation	Restless, overactive
Avoids social situations	Distractible, inattentive	Leadership	Sad, unhappy
Avoids performance	Dizziness	Lonely	Sees things others don't
Argues/talks back	Doesn't give up	Loss of interest in enjoyable activities	Sensitive
Attention problems	Enjoys being alone	Low Tolerance	Specific fears
Bed wetting	Enjoys performing	Mental confusion	Stealing or other criminal activity
Bullies/teases	Feels inferior	Moody / mood swings	Stress
Bossy	Grateful	Negative outlook	Strong sense of self
Concentration problems	Grief	Nervous habits	Suspicious
Concern for others	Guilt	Nightmares	Trusting
Conflicts with friends	Headaches	Oppositional	Uncooperative
Conflicts with authority	Hears things others don't	Panic attacks	Unusual thoughts
Constipation/diarrhea	Highly motivated	Patient	Unusually sensitive to texture, food, sound, etc
Creative	Hostile, destructive	Perfectionism	Other:
Cries easily/frequently	Impulsivity	Poor self esteem	
Dependent, immature	Irrational thoughts	Positive outlook	
Depressed	Isolating	Resilient	
Creative	Irritability	Stomach pain/nausea	

Development	Are there any problems noted in your teen's developmental history?	
	Has there been any life events/ issues that have affected your teen significantly?	
Health	How would you describe your teen's level of physical activity?	
	Has your teen had any difficulty with eating/appetite?	
	Has your teen had any difficulty with sleep?	
	Has your teen had any physical problems (allergies/surgeries/hospitalizations /etc)?	
	Does your teen take any medication regularly (prescription or over the counter)?	
	Date of last physical exam	
Safety	Does your teen have any history of abuse? physical,sexual,emotional,neglect	
	Is there any type of abuse currently occurring?	
	Does or has your teen have/had any self-harming behaviors?	
	Has your teen ever talked about or attempted suicide?	
	Has your teen ever harmed someone else?	
	Has your teen been a victim of or a witness to crime / violence?	

Family	With whom does the teen live?	
	What is the relationship like between parents?	
	What is the father's relationship like with the teen?	
	What is the mother's relationship like with the teen?	
	Do parents have any significant physical or mental health issues?	
	Are parents separated/divorced?	
Emotional	Does your teen participate in any extracurricular activities / hobbies?	
	How would you describe your teen's typical mood?	
	How would you describe your teen's typical level of anxiety?	
	Where is your teen's greatest need for growth?	
	What is your teen's greatest strength?	
Social	How would you describe your teen's friendships?	
	What are your teen's social skills like?	