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	Parent / Guardian Completing This Form

MENTAL HEALTH HISTORY QUESTIONNAIRE – YOUTH

All questions contained in this questionnaire are strictly confidential and will become part of your child's mental health record.

Are you the child's parent / legal guardian? Yes No **if divorced, are you the managing conservator?** Yes No

Child's Full Name: _____ M F **DOB:** _____

Resides With: Both Biological Parents Mother Only Father Only Blended Family Adoptive Family Other:

Why are you seeking counseling?	How long has this been a problem? Why Now?
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Recent Changes	Child's Response
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Recent Losses	Child's Response
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Education: Circle highest grade completed: **K 1 2 3 4 5 6 7 8 9 10 11 12** Circle any grades repeated: **K 1 2 3 4 5 6 7 8 9 10 11 12**
Is your child in any of the following school programs? Special Ed TAG Head Start Alternative Setting

Name of School _____ **SCHOOL DISTRICT:** _____ **I.S.D.** _____

Difficulties None Reading / Dyslexia Writing / Dysgraphia Mathematics / Dyscalculia Other:

AXIS II & III DEVELOPMENTAL AND MEDICAL HISTORY

Check all that apply to your child

Colicky Developmental Disorders Autism / Asberger's ADD PICA / Feeding Difficulties Bed Wetting
 Gastrointestinal Streptococcus /Rheumatic Fever Meningitis Pneumonia Head Trauma Language Delays
 Cardiovascular Seizures Cancer Stroke Diabetes Arthritis Asthma Mental Disorder / Illness
 Fetal Alcohol Syndrome Confusion Body Aches / Chronic Pain Thyroid Disease Other:

AXIS IV – HOUSEHOLD CURRENT STRESSFUL EVENTS – WITHIN THE LAST 6 – 12 MONTH PERIOD

Check all that apply to your child / household

Family problems Attachment difficulty Child care Economic / Housing / Health Legal Problems
 Parenting differences Separation anxiety Crime victim Trauma / Abuse Substance Abuse
 Divorce /blended family Custody / /visitation Grief / Loss Relocation Birth of sibling School problems

CHILD'S MEDICAL / MENTAL HEALTH HISTORY

Known Allergies None Environmental Food Medication **Reaction:** _____

Last Physical **Date:** _____ **Overall Health:** Excellent Good Fair Poor Unsure

Primary Care **Physician's Name:** _____ **Phone: ()** _____

Has your child ever been hospitalized for a psychiatric condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+	Previous Diagnosis	Date of last admission:
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Is your child currently taking a prescribed PSYCHOTROPIC MEDICATION? No Yes **How long?** _____

List them:

Prescribing Dr's Name: _____ **Phone:** _____

Other prescribed medications / over-the-counter drugs, (vitamins, inhalers)

List them:

Has your child ever tried to harm him / herself? No Yes If Yes, 1 2 3+ **Last time, when?** _____

Has anyone in your family committed suicide? No Yes If Yes, Whom? _____ When? _____

FAMILY HISTORY OF MENTAL / NERVOUS DISORDERS:

Depression Anxiety Disorders / Panic Disorder Bi Polar (Manic Depressive) Obsessive-Compulsive Disorder Schizophrenia Psychosis
 Substance Abuse / Dependency ADD/ ADHD Personality Disorders Other: _____

Child's Name: _____

PROBLEM CHECKLIST

Please rate each of the following problem areas that have been present in your child during the past year or have occurred prior to the past year if they clearly contribute to the reasons for seeking treatment.

0 = No significant problem

1 = Mild or transient

2 = Moderate

3 = Severe

4 = Extreme

9 = Unknown or cannot categorize

0 1 2 3 4 9	Easily distracted	0 1 2 3 4 9	Talks excessively
0 1 2 3 4 9	Does not follow rules of structured games	0 1 2 3 4 9	Engages in potentially dangerous activities without considering the consequences
0 1 2 3 4 9	Has difficulty organizing tasks	0 1 2 3 4 9	Does not complete tasks
0 1 2 3 4 9	Shifts from uncompleted task to another	0 1 2 3 4 9	Has excessive or unrealistic worry about future
0 1 2 3 4 9	Steals from family members or others	0 1 2 3 4 9	Runs away from home
0 1 2 3 4 9	Tells lies	0 1 2 3 4 9	Sets fires
0 1 2 3 4 9	Is truant from school	0 1 2 3 4 9	Destroys own property
0 1 2 3 4 9	Destroys property of others	0 1 2 3 4 9	Has used a weapon in a fight
0 1 2 3 4 9	Is cruel to animals	0 1 2 3 4 9	Initiates fights
0 1 2 3 4 9	Loses temper	0 1 2 3 4 9	Argues with adults
0 1 2 3 4 9	Defies or refuses requests made by adults	0 1 2 3 4 9	Deliberately does things that annoy others
0 1 2 3 4 9	Blames others for his / her mistake	0 1 2 3 4 9	is touchy or easily annoyed by others
0 1 2 3 4 9	Is angry and / or resentful	0 1 2 3 4 9	Is spiteful and vindictive
0 1 2 3 4 9	Swears or uses abusive language	0 1 2 3 4 9	Worries about harm coming to parent or others
0 1 2 3 4 9	Refuses to go to school	0 1 2 3 4 9	Resists separation from caretaker
0 1 2 3 4 9	Has physical complaints on school days	0 1 2 3 4 9	Does not do chores
0 1 2 3 4 9	Is self-conscious	0 1 2 3 4 9	Has low energy level
0 1 2 3 4 9	Has tics or spasms	0 1 2 3 4 9	Hurts self on purpose (<i>i.e. cutting, burning, hitting</i>)
0 1 2 3 4 9	Has problems with bowel control	0 1 2 3 4 9	Has problems with wetting / bed wetting
0 1 2 3 4 9	Has suicidal thoughts / attempts	0 1 2 3 4 9	Displays inappropriate sexual behavior
0 1 2 3 4 9	Has trouble getting along with peers	0 1 2 3 4 9	Has problems with speech
0 1 2 3 4 9	Withdraws into an imaginary world	0 1 2 3 4 9	Has mood swings
0 1 2 3 4 9	Has problems remembering	0 1 2 3 4 9	Sees or hears things that are not there
0 1 2 3 4 9	Cries	0 1 2 3 4 9	Has over-active behavior
0 1 2 3 4 9	Does not show emotions	0 1 2 3 4 9	Has problems with sleeping
0 1 2 3 4 9	Does not do homework	0 1 2 3 4 9	Grades have declined from previous years
0 1 2 3 4 9	Has eating problems	0 1 2 3 4 9	Lacks motivation
0 1 2 3 4 9	has poor school grades	0 1 2 3 4 9	Has no known goals
0 1 2 3 4 9	Suspended or expelled from school	0 1 2 3 4 9	Needs reassurance about a variety of things
0 1 2 3 4 9	Is suspected or known to drink alcohol	0 1 2 3 4 9	Expresses negative self-thoughts
0 1 2 3 4 9	Is suspected or known to use drugs	0 1 2 3 4 9	Unusual repetitive behaviors / rituals
0 1 2 3 4 9	Other (<i>Specify</i>)	0 1 2 3 4 9	Other (<i>Specify</i>)

Child's Name: _____

SYMPTOM INVENTORY

Check all that apply to your child in the past 30 days.

<input type="checkbox"/> Headache	<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Poor Concentration
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Difficulty with Separation / Attachment	<input type="checkbox"/> Can't Make Friends / keep friends
<input type="checkbox"/> Low Energy	<input type="checkbox"/> Feel Panicky	<input type="checkbox"/> Anorexia/Bulimia Eating Disorder
<input type="checkbox"/> No Appetite	<input type="checkbox"/> Fears / Phobias (specific things or events)	<input type="checkbox"/> Home Conditions Poor
<input type="checkbox"/> Over-Eating	<input type="checkbox"/> School Problems / or School Refusal	<input type="checkbox"/> Unable To Have Fun
<input type="checkbox"/> Stomach Distress	<input type="checkbox"/> Avoidant Behavior	<input type="checkbox"/> Self Injury – cutting, picking, pulling hair
<input type="checkbox"/> Bowel Disturbances	<input type="checkbox"/> Trauma / Abuse History	<input type="checkbox"/> Impulse control problems
<input type="checkbox"/> Always Feel Tired	<input type="checkbox"/> Guilty Feelings	<input type="checkbox"/> Can't Make Decisions
<input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Irritability	<input type="checkbox"/> Angry Outbursts
<input type="checkbox"/> Appears confused / disoriented	<input type="checkbox"/> Difficulty with transitions / change	<input type="checkbox"/> Depressed
<input type="checkbox"/> Unable to Relax	<input type="checkbox"/> Obsessive thoughts (over and over again)	<input type="checkbox"/> Sexual Identity / Orientation Confusion
<input type="checkbox"/> Recurrent Dreams	<input type="checkbox"/> Obsessive behavior (over and over again)	<input type="checkbox"/> Daycare Issues
<input type="checkbox"/> Nightmares / Night terrors	<input type="checkbox"/> Afraid of people	<input type="checkbox"/> Poor communication
<input type="checkbox"/> Hallucinations / Delusions	<input type="checkbox"/> Worried / Anxious / General (non-specific)	<input type="checkbox"/> Isolates self from others
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Currently my child:

- | | |
|---|--|
| <input type="checkbox"/> Participates in school –related extracurricular activities | <input type="checkbox"/> Is employed _____ hours per week. |
| <input type="checkbox"/> Participates in other extracurricular activities | <input type="checkbox"/> volunteers _____ hours per week |

Has your child ever been accused or suspected of any illegal activities? No Yes If yes, describe:

What are your counseling goals for your child?

What are your child's strengths?

Please add any additional information that you think might be helpful in understanding your child.

Parent / Legal Guardian's Signature

Today's Date