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Rv.9/08.1

Date:

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?**	
Recent Changes		**Child's Response**	
Recent Losses		**Child's Response**	
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?	☐ **No** ☐ **Yes** ☐ 1 ☐ 2 ☐3+	**Previous Diagnosis**	**Date of last admission:**

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

Rating	Problem	Rating	Problem
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.e. cutting, burning, hitting)*
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 *(Specify)*	0 1 2 3 4 9	Other *(Specify)*

Child's Name:____

SYMPTOM INVENTORY

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

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

Currently my child:

☐ Participates in school –related extracurricular activities

☐ Is employed _____________ hours per week.

☐ Participates in other extracurricular activities

☐ 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 thing might be helpful in understanding your child.

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Parent / Legal Guardian's Signature | Today's Date