Patient name			
MHN	DOB	Age	Gender

Child/Adolescent

Psychiatric/MH Questionnaire

Appointment date (m/d/y) _____ /_____ /_____ Form completed by _____

Race/Ethnic background _____ Language preference _____

Cultural preferences_____ Preferred pronoun _____

Referral source

Referred by _____ Child's primary physician _____

Concerns

Treatment needs (concerns/problems you wish to discuss) _____

Treatment goals/preferences_____

Strengths _____

Review of symptoms

Check (✓) any of the following areas that cause major issues for your child:

- ☐ Impulsive
- ☐ Lying
- ☐ Stealing
- ☐ Inattention
- ☐ Daydreaming
- ☐ Worries
- ☐ Fire setting
- ☐ Nail biting
- ☐ Frequent crying
- ☐ Irritability
- ☐ Panic attacks
- ☐ Suspiciousness
- ☐ Shy or timid
- ☐ Destruction of property
- ☐ Animal cruelty
- ☐ Defiance and disobedience
- ☐ Thoughts of suicide
- ☐ Misinterprets ideas
- ☐ Frequent temper tantrums
- ☐ Police/Legal trouble
- ☐ Extreme mood swings
- ☐ Social withdrawal
- ☐ Wetting or soiling
- ☐ Poor eye contact
- ☐ Aggression to self/self-abuse
- ☐ Suicide attempt
- ☐ Negative comments about self
- ☐ Concern about drugs/alcohol/smoking
- ☐ Repeats certain act over and over
- ☐ Avoid certain things or places
- ☐ Uncomfortable in social situations
- ☐ Unusual behavior, explain _____
- ☐ Running away from home or school
- ☐ Depression, sadness or unhappiness
- ☐ Hyperactive or unable to sit still
- ☐ Body aches, headaches, stomach aches
- ☐ Sleep problems/nightmares
- ☐ Collects things, specify _____
- ☐ Aggression to others, specify _____

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

School history

School _____ Grade _____

☐ Repeated any grades (what grade _____)

Preferred areas of study

What subjects does your child do well in _____

What subjects does your child have the most difficulty with _____

Does your child: ☐ Like school ☐ Dislike school

Future educational goals

What does your child want to do when their schooling is completed _____

Past intelligence testing/neuro psychological testing _____

Do your child's emotions interfere with learning _____

Emotional barriers to learning

Cognitive limitation for learning:
☐ Learning disability (LD) ☐ Intellectual disability ☐ Traumatic brain injury ☐ Seizures

In a special education program:
☐ IEP (learning disability) ☐ 504 plan (ADHD, emotional challenges) ☐ Personal learning plan (behavioral)

☐ Suspected learning problems (specify _____)

Desire/Motivation for learning: ☐ Strong ☐ Average ☐ Weak

Barriers to communication: ☐ Non English speaking ☐ English as second language
☐ Hearing impaired ☐ Speech/Language services

Physical limitations for learning: ☐ Yes ☐ No

Behavioral problems in school:
☐ Refusal to go to school ☐ Skipping school ☐ Verbal outbursts ☐ Physical outbursts

Psychiatric history

Have you ever tried psychotherapy for your child: ☐ Yes ☐ No

If yes:

1. Name of therapist _____ When _____
   Where _____
2. Name of therapist _____ When _____
   Where _____
3. Name of therapist _____ When _____
   Where _____

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Has your child ever been hospitalized for behavioral or emotional problems: ☐ Yes ☐ No

If yes: When _____ Where _____

Reason _____

Does your child have any psychiatric diagnoses: ☐ Yes ☐ No

If yes, what _____

Is your child currently on medications: ☐ Yes ☐ No

If yes:

Name of Medication	Dosage

Over-the-counter medications _____

Has your child been on medications for behavioral or emotional problems in the past: ☐ Yes ☐ No

If yes, list _____

_____

_____

Any adverse reaction to any of the medications: ☐ Yes ☐ No

If yes:

Name of Medication	Effect

Trauma history

Has your child ever experienced any trauma: ☐ Yes ☐ No

If yes, type of trauma: ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Traumatic loss or death

☐ Motor vehicle accident ☐ Witnessed sudden death ☐ Witnessed violence ☐ _____

Community-based and home-based services:

☐ Social services ☐ Comprehensive community services (CCS) ☐ Coordinated services team (CST)

☐ Aging and disability resource connection (ADRC) ☐ Day treatment ☐ Court-ordered services

☐ Other _____

County caseworker: ☐ Yes ☐ No

If yes, name _____

Has your child ever been placed in a foster home, group home, or residential treatment center: ☐ Yes ☐ No

If yes: Where _____ When _____

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Medical history

Date of last physical evaluation _____ Physical pain concern: ☐ Yes ☐ No

Check (✓) any of the following that your child has experienced:

- ☐ Meningitis
- ☐ Encephalitis
- ☐ Seizure/Convulsion
- ☐ Tubes placed in ears
- ☐ Pneumonia
- ☐ Asthma
- ☐ Heart disease/problem
- ☐ Nervous twitches or tics
- ☐ Tremor
- ☐ Lead poisoning
- ☐ Recurrent headaches/stomach aches
- ☐ Severe injuries or broken bones
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Head injuries

Nutritional assessment

Food allergies: ☐ Yes ☐ No

Weight loss/gain of 10 or more pounds in past 3 months: ☐ Yes ☐ No

Decrease in food intake and/or appetite: ☐ Yes ☐ No

Binge eating: ☐ Yes ☐ No

Self induced vomiting: ☐ Yes ☐ No

Intentional restriction of food intake: ☐ Yes ☐ No

Dental problems: ☐ Yes ☐ No

Hospitalizations/Operations	Age	Description

Allergies: ☐ Yes ☐ No

If yes, specify _____

Immunizations up-to-date: ☐ Yes ☐ No

For adolescent females only:

Onset of menstrual period: ☐ Yes ☐ No

Have menstrual periods been unusual or irregular: ☐ Yes ☐ No

Any past pregnancies: ☐ Yes ☐ No

Patient name	MHN	DOB	Age	Gender

Developmental history

Child's mother had a total of _____ pregnancies and has _____ living children

Any complications with pregnancy..... ☐ Yes ☐ No
If yes, specify _____
_____

Was mother exposed to medications during pregnancy ..... ☐ Yes ☐ No
If yes, what _____
_____

Was mother exposed to x-ray..... ☐ Yes ☐ No

Did mother use alcohol or illicit drugs during pregnancy ..... ☐ Yes ☐ No

Did mother use tobacco during pregnancy ..... ☐ Yes ☐ No

Pregnancy was for how long:
☐ Full term ☐ Preterm ☐ Post term

Delivery was:
☐ Vaginal ☐ C-section ☐ Forceps

Birth weight _____

Any complications postpartum such as infection, bleeding, postpartum depression (baby blues)..... ☐ Yes ☐ No
If yes, specify _____
_____

☐ Baby came home on time
☐ Baby was transferred to the NICU for _____ days

Looking back through infancy and early childhood, how would you describe your child's activity level:
☐ High ☐ Low ☐ Average

Was the baby "colicky" ..... ☐ Yes ☐ No

Did the baby have any problems bonding..... ☐ Yes ☐ No

Trouble with feeding..... ☐ Yes ☐ No

Trouble with sleep..... ☐ Yes ☐ No
If yes, what age _____

How would you describe his/her temperament:
☐ Easy baby ☐ Challenging baby ☐ Average
☐ Slow to warm up ☐ Moderate

Looking back to the first 1 – 2 years of your child's life, how would you describe your child's development (sitting, walking, talking, toilet training, etc.):
☐ Mostly on time or early ☐ Mostly late or delayed
☐ On time, except _____

Did your child have any problems separating from you..... ☐ Yes ☐ No
If yes, specify _____
_____

Early childhood program ..... ☐ Yes ☐ No

Birth to 3 years old ..... ☐ Yes ☐ No

Head Start ..... ☐ Yes ☐ No

Patient name	MHN	DOB	Age	Gender

Family history of psychiatric/medical problems

Check (✓) all that apply:

Psychiatric/Medical Problems	Biological		Relative (Specify)	Psychiatric/Medical Problems	Biological		Relative (Specify)
	Mother	Father			Mother	Father	
Anxiety				Tourette's/Tics			
Depression				Use of psychiatric medications			
Mood swings							
Bipolar				Psychiatric hospitalization			
Suicide attempt							
Alcohol use				School problems			
Drug use				Cognitive disability			
Gambling				Arrest, legal problems, felonies			
Hyperactivity				Thyroid			
Temper problems				Diabetes			
Paranoia				Sudden cardiac deaths			
Hallucinations				Seizure or epilepsy			
Eating disorders				Cancer			
Panic attacks				Other			

Family membership

Who does your child live with now:

Name	Age	Relationship to Child	Education	Occupation	Health

Birth parent information (if not listed above):

Birth Parent Name	Age	Education	Job
Mother			
Father			

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Marital information

Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Never married ☐ Cohabitating (live together)

Who has primary physical placement: ☐ Both parents ☐ Mother ☐ Father ☐ Other, specify _____

Visitation schedule _____

Family stressors

Check (✓) if any of the following have occurred in the last 12 months:

☐ Parents separated ☐ Family moved ☐ Exposure to discrimination

☐ Parents divorced ☐ Child changed school ☐ Poverty

☐ Parental conflict ☐ Parent changed/started job ☐ Other _____

Has a parent or other adult in the home served in the military: ☐ Yes ☐ No

What particular religion do you identify with _____

Social information

Problems making friends in the neighborhood and/or at school _____

How does your child relate to his/her siblings _____

Quality/Quantity of social support _____

Thank you for taking time to complete this questionnaire.

