Patient name			
MHN	DOB	Age	Gender

Child/Adolescent

Psychiatric/MH Questionnaire

Appointment date (month/day/year)	Therapist
Address	
School	Grade

Class arrangement:

☐ Special ☐ Regular ☐ Combination ☐ Chapter 1 ☐ Individual educational plan evaluation

Current living arrangement:

☐ Parent home ☐ Foster home ☐ Residential facility

☐ Other _____

Caretaker/Relationship	Caretaker/Relationship
Name	Name
Address	Address
Home phone number	Home phone number
Work phone number	Work phone number
Parent or legal guardian (person legally authorized to sign for medication and treatment)	
Address and phone number if different than above	

Referral source

Referred by _____

Child's primary physician _____

Address _____

Would you like a copy of the evaluation from this appointment sent to the child's doctor: ☐ Yes ☐ No

Would you like a copy of the evaluation from this appointment sent to someone else: ☐ Yes ☐ No

If yes, specify to whom _____

Patient name	MHN	DOB	Age	Gender

Concerns

What concerns/problems do you wish to discuss in the appointment _____

_____

_____

What do you believe caused these problems _____

_____

How long have you been concerned about your child or teenager _____

What are your goals for the appointment _____

_____

Review of symptoms

Check (✓) any of the following areas that may create a major issue for your child or teenager:

- ☐ Frequent interruption of adult conversation
- ☐ Impulsive and always on the go
- ☐ Hyperactive or unable to sit still
- ☐ Fails to give close attention to details or makes careless mistakes
- ☐ Forgetful
- ☐ Daydreaming
- ☐ Defiance and disobedience
- ☐ Frequent temper tantrums
- ☐ Problems making friends in neighborhood

  _____
- ☐ Problems making friends in school

  _____
- ☐ Aggression to self
- ☐ Self abuse/mutilation
- ☐ Aggression to others, specify _____
- ☐ Destruction of property
- ☐ Animal cruelty
- ☐ Lying
- ☐ Stealing
- ☐ Fire setting
- ☐ Running away from home
- ☐ Running away from school
- ☐ Police/Legal trouble
- ☐ Concern about drugs
- ☐ Concern about alcohol
- ☐ Tobacco use/smoking
- ☐ Depression, sadness or unhappiness
- ☐ Extreme mood swings
- ☐ Withdrawal
- ☐ Irritability
- ☐ Body aches, headaches, stomachaches
- ☐ Frequent crying
- ☐ Suicide attempt
- ☐ Thoughts of suicide
- ☐ Negative comments about self
- ☐ Sleep problems
- ☐ Appetite problems
- ☐ Worries
- ☐ Nightmares
- ☐ Shy or timid
- ☐ Nail biting

Patient name	MHN	DOB	Age	Gender

- ☐ Bed wetting/soiling
- ☐ Repeats certain act over and over
- ☐ Avoid certain things or places
- ☐ Uncomfortable in social situations
- ☐ Panic attacks
- ☐ Prefers younger children as playmates
- ☐ Prefers older children as playmates
- ☐ Developmental delays
- ☐ Speech problems or delays
- ☐ Collects things, specify _____
  _____
- ☐ Misinterprets ideas
- ☐ Strange behavior, explain _____
  _____
- ☐ Suspiciousness
- ☐ Paranoia
- ☐ Unusual thoughts or ideas

Check (✓) if your child has any of the following school problems:

- ☐ Learning problems
- ☐ Lack of interest in school
- ☐ Skipping school
- ☐ School suspension
- ☐ Below average grades
- ☐ Reading problems
- ☐ Refusal to go to school
- ☐ Behavioral problems in school
- ☐ Repeated any grade (what grade _____)

Psychiatric history

Have you ever tried therapy for your child or teenager: ☐ Yes ☐ No

If yes:

1. Name of therapist _____ When _____

   Where _____ For what problems _____

   Outcome _____

2. Name of therapist _____ When _____

   Where _____ For what problems _____

   Outcome _____

3. Name of therapist _____ When _____

   Where _____ For what problems _____

   Outcome _____

Child/Adolescent

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 diagnosis: ☐ Yes ☐ No

If yes, what _____

Is your child currently on medications: ☐ Yes ☐ No If yes:

Name of Medication	Dosage

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

Patient name	MHN	DOB	Age	Gender

Abuse history

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

If yes, type of abuse: ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect

Any past dangerous behavior: ☐ Yes ☐ No

If yes, specify _____

Any past psychological testing: ☐ Yes ☐ No

If yes, where _____ (bring copy of report to evaluation)

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

If yes: Where _____

When _____

Medical history

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

- ☐ Meningitis
- ☐ Encephalitis
- ☐ Seizure/Convulsion
- ☐ Ear infection
- ☐ Tubes placed in ears
- ☐ Sinus infection
- ☐ Pneumonia
- ☐ Asthma
- ☐ Heart disease/problem
- ☐ Nervous twitches or tics
- ☐ Tremor
- ☐ Recurrent headaches/stomachaches
- ☐ Severe injuries or broken bones
- ☐ Lead poisoning
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Concussion
- ☐ Head injuries
- ☐ Skull fracture

Hospitalizations/Operations	Age	Description

Patient name	MHN	DOB	Age	Gender

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

Developmental history

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

Any complications with pregnancy: ☐ Yes ☐ No

If yes, specify _____

Did mother have any fevers, illness, or infections: ☐ Yes ☐ No

Was mother exposed to medications: ☐ 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

How long did labor last _____

Apgar score (if you remember) _____

Birth weight _____ Length _____

Any complications postpartum such as infection, bleeding, postpartum depression (baby blues): ☐ Yes ☐ No

If yes, specify _____

Baby: ☐ Came home on time ☐ Was transferred to an NICU for _____ days

Looking back through infancy and early childhood, how would you describe activity level:

☐ High ☐ Low ☐ Average

Did the baby cry more than average: ☐ Yes ☐ No

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 ☐ Difficult baby

☐ Challenging baby ☐ Slow to warm up ☐ Colicky ☐ Moderate

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

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

Head banging: ☐ Yes ☐ No If yes, what age _____

Early childhood program: ☐ Yes ☐ No If yes, specify _____

Attending pre-K: ☐ Yes ☐ No

Social history

Aggressive: ☐ Yes ☐ No

Mixes well with other children: ☐ Yes ☐ No

Made good eye contact: ☐ Yes ☐ No

Any other thing in his/her childhood _____

_____

Family history of psychiatric problems

Check (✓) all that apply:

Psychiatric Problems	Biological		Relative (Specify)	Psychiatric Problems	Biological		Relative (Specify)
	Mother	Father			Mother	Father	
Anxiety				Hallucinations			
Depression				Tourette's/Tics			
Mood swings				School problems			
Manic depression				Arrest, legal problems, felonies			
Suicide attempt							
Alcohol use				Mental retardation			
Drug use				Eating disorders			
Hyperactivity				Panic attacks			
Temper problems				Seizure or epilepsy			
Paranoia				Gambling			

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

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			

Family stressors

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

- ☐ Parents separated
- ☐ Parents divorced
- ☐ Parental conflict
- ☐ Family moved
- ☐ Child changed school
- ☐ Parent changed/started job
- ☐ Death of a family member or friend
- ☐ Exposure to violence
- ☐ Other _____

_____

Marital information

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

Who has legal custody: ☐ Both parents ☐ Mother ☐ Father ☐ Other, specify _____

Visitation schedule _____

Patient name	MHN	DOB	Age	Gender

Social information

How does the child or teenager relate to his/her friends _____

_____

_____

How does the child or teenager relate to his/her siblings _____

_____

_____

What is your child's strengths (talents, hobbies, interests) _____

_____

_____

_____

_____

_____

_____

Thank you for taking time to complete this questionnaire.

_____ _____ _____/_____/_____

Patient signature (Patient's legal representative) (Relationship) Date (month/day/year)

