Mental and Behavioral Health Questionnaire

Thank you for taking the time to complete this form so that we can better serve your child. The evaluation process for mental or behavioral health conditions typically includes several steps; this survey is the first step. Throughout the process, your child's doctor may recommend counseling, medication, or a referral to a mental or behavioral health specialist. *Please note that a full diagnosis is not often made and medication is not often prescribed at the very first visit with the doctor.*

Child's Name:____

Child's Date of Birth:_________________

Name of Parent / Guardian filling out this form:__________________________________

Relationship to Child: ________________

What are your main concerns about your child's mental or behavioral health?

School

Child's grade in school:________ Name of school:_________________________

What were your child's most recent grades on his or her report card?

Has your child ever had to repeat a grade?

Is your child in any special education classes or RTI?

Does your child have an IEP or 504 plan?

Has your child ever undergone a psychoeducational evaluation?

Has your child ever been diagnosed with a learning disability or dyslexia?

Has your child ever been suspended or expelled from school?

Mental Health

Has your child been diagnosed with a mental or behavioral health disorder previously? If so, which disorder and when?

Has your child previously received mental or behavioral health treatment or counseling? If so, where and when?

Is your child currently in counseling? If so, where?

Has your child experienced any recent stressors (e.g. recent move, new school, parental divorce)?

Circle all symptoms that apply to your child:

Sleep problems
Fatigue or low energy
Appetite or weight changes
Difficulty concentrating
Lack of interest in activities
Withdrawal from family and friends
Feeling down, depressed, irritable or hopeless
Suicidal thoughts, threats, plans, or attempts
Excessive worry or fearfulness
Anxiety or panic attacks
Nightmares
Frequent tantrums
Separation problems, clingy
School refusal

Perfectionism, obessive behaviors
Bedwetting or soiling
Headaches or stomachaches
Odd hand or motor movements
Bursts of high energy
Strange beliefs
Hallucinations
Concerns about sexual identity

Can't sit still
Talks excessively, interrupts
Short attention span, distractible
Forgetful, memory problems
Problem completing schoolwork
Impulsive
Aggressive behavior
Difficulty following rules
Picked on, bullied by peers

Lying, stealing
Being destructive
Hurting others
Trouble with the law
Acts as if has no fear
Short tempered, easily annoyed
Argumentative, defiant
Disobedient
Running away
Truancy, skipping school
Drug use
High risk sexual activty

Other symptoms not noted above:____

Please list all previous medications that your child has been prescribed for mental / behavioral health:

Name of Medication	Highest Dose of this Medication	Dates of Treatment with this Medication	Who Prescribed this Medication	Reason No Longer Taking this Medication

Developmental / Medical History

Was your child born prematurely? If so, how many weeks?

Were there any difficulties with the pregnancy or labor / delivery?

Did your child have to stay in the hospital (i.e. NICU) for a prolonged time when he or she was born?

Did your child walk on time (i.e. by age 13-14 months)?

Did your child talk on time (i.e. first word by age 12 months; two word phrases by age 2)?

Has your child lost any skills that he or she used to have?

When does your child go to bed at night and get up in the morning?

How many hours per day does your child use a screen (including phone, TV, computer, tablet, video games)?

Has your child ever had a concussion or head injury?

Does your child have any chronic medical problems?

Family Health

Who lives at home with your child? (You can just say, "mom, dad, sister, etc")

Are there any family members with any of the mental or behavioral health conditions below? Circle all that apply.

Depression
Anxiety
Bipolar Disorder
Schizophrenia / Psychosis
OCD
ADHD
Learning Disability
Drug or Alcohol Abuse

Other Mental Health Disorder:________________________________

Has your child ever experienced physical, sexual, or psychological abuse? If so, was this abuse reported to DCS / police?

Has your family ever experienced domestic violence, homelessness, drug abuse, alcoholism, incarceration or suicide?

Has DCS ever been involved with your family?