Western Wisconsin Health

MENTAL HEALTH CHILD MEDICAL QUESTIONNAIRE – 12 YEARS AND YOUNGER

Childs Name: _____ Birthdate: _____ Today's Date: _____

Primary Care Physician: _____ Medical Clinic: _____

Address/City/State/Zip: _____ Clinic Telephone: _____

1. May we contact your Physician?: (Please Circle) YES NO

2. When was the last time you saw your physician?: (Date) _____

3. What medical problems did you see your physician for?: _____
_____

4. What medical problems, if any, are you currently having?: _____
_____

5. Are those problems being treated?: (Please Circle) YES NO By Whom?: _____

6. What medications are you currently using? Please include over-the counter medications as well as herbal supplements:
_____

7. List any medical problems that your child has been treated for in the past?: _____
_____

8. Is there a family history of medical problems?: (Please Circle) YES NO If yes, please list: _____
_____

9. Is there any history of mental illness in your family?: (Please Circle) YES NO If yes, please describe: _____
_____

10. Have you had any previous mental health treatment? (Please Circle) YES NO If so, please list with whom, dates of treatment, for what problems, medications used with dosages and outcome of treatment.: _____
_____

11. Please list any hospitalizations, serious illnesses, or operations including dates and where treated: _____
_____

12. Do you have any hearing or sight loss, speech impairment, learning disability or other perceptual deficit/impairment? (Please Circle) YES NO If yes, please describe: _____
_____

13. Does your child use alcohol or drugs? (Please Circle) YES NO Type Used: _____
How Long?: _____ Weekly amount: _____

14. Has your child had any treatment for alcohol or drug problems (Please Circle): YES NO When, Where, and Outcome of treatment: _____
_____

15. Is there any family history of drugs or alcohol problems?: _____
_____

16. Is there anything else in your child's medical history that would be helpful for us to know?: _____
_____

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NEW CLIENT INFORMATION
PLEASE PRINT

Biological Mother's Address **Biological Father's Address**

Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone: _____ Work Phone: _____ Cell Phone: _____	Home Phone: _____ Work Phone: _____ Cell Phone: _____

Person(s) living with child (brothers, sisters, relatives, friends)

Name:	Age:	□ Sister □ Brother □ Step-Sister □ Step-Brother □ Other
Name:	Age:	□ Sister □ Brother □ Step-Sister □ Step-Brother □ Other
Name:	Age:	□ Sister □ Brother □ Step-Sister □ Step-Brother □ Other
Name:	Age:	□ Sister □ Brother □ Step-Sister □ Step-Brother □ Other
Name:	Age:	□ Sister □ Brother □ Step-Sister □ Step-Brother □ Other
Name:	Age:	□ Sister □ Brother □ Step-Sister □ Step-Brother □ Other

Child's Daycare / Preschool or School

Name of School:	Director or Principal:
Street:	Primary Teacher:
City, State, Zip:	Other Significant Teacher, Counselor, Coach, etc.:
School Phone:	Other Significant Teacher, Counselor, Coach, etc.:

Child's Academic Status

Child's Grade or Level:	Child's General Academic Progress: □ Far Below Grade □Below Grade □ At Grade □ Above Grade
Has the child been evaluated for any special needs by the school? □ Yes □ No	If yes, does the child have an Individual Education Plan (IEP) in force? □ Yes □ No

Child's Physician **Child's Current/Previous Therapist (if any)**

Physician's Name:	Therapists Name:
Physician's Group or Clinic:	Therapist's Group or Clinic:
Street:	Street:
City, State, Zip	City, State, Zip
Office Phone: _____ Fax Phone: _____	Office Phone: _____ Fax Phone: _____
Did the Physician refer the child? □ Yes □ No If no, may we contact the physician? □ Yes □ No	Did the therapist refer the child? □ Yes □ No

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CHILD HISTORY CHECKLIST

What concerns you most about this child? Has the child previously been evaluated and / or treated for this problem? □ Yes □ No
What are you hoping we can do to help your child with this problem?

Please answer the following questions by filling in the check to indicate Yes, No, or Not sure:

Child Medical / Developmental History

Has the child had any of the following problems?	Yes	No	Not Sure
1. Difficult pregnancy / labor, delivery			
2. Problems with health, feeding and / or sleeping during first year of life			
3. Slow in learning to sit up, crawl, walk, feed self and / or dress self			
4. Speech and / or hearing problems			
5. Many ear infections requiring medication			
6. Frequent headaches, stomach aches / nausea, or other pains			
7. Major illness or hospitalizations (not including normal birth)			
8. Prescription medications taken within the past 2 months			
9. Other Problem(s)			

Child Behavioral History

Has your child shown any of the following behaviors within the past 6 months?	Yes	No	Not Sure
10. Performing below expectations at school in one or more academic areas			
11. Age-inappropriate fears, anxieties (including separation anxiety and school anxiety)			
12. Social withdrawal, excessive shyness, or avoidance behaviors			
13. Sleep disturbances (night terrors, nightmare, multiple night wakening, seeking others beds)			
14. Immature social skills, self-help skills, and / or communication skills			
15. Poor gross-motor skills (e.g. running) and / or poor fine motor skills (e.g. drawing, handwriting, using scissors)			
16. Antisocial behavior (fighting, theft, fire-setting, cruelty to animals, deceitfulness, drug / alcohol use, etc.			
17. Learning problems involving reading, writing, or math			
18. Abnormal responses to pain, sound, touch, clothing textures, light, and / or odors			
19. Tics, nervous habits, or unusual mannerisms			
20. Very strange or bizarre behaviors, interests, or ideas non-useful rituals or rigid rule-following			
21. Watching more than 2 hours of TV / Videos per day			
22. Talking about or threatening to hurt self			
23. Other behaviors or concerns:			

Family Medical / Behavioral History

Have any of the child's biological parents, siblings, or relatives had any of the following problems?	Yes	No	Not Sure
24. Migraine headaches, seizures, or other neurological conditions			
25. Thyroid condition			
26. Learning Problems			
27. Attention problems (with or without hyperactivity)			
28. Psychological problems			
29. Trouble with the law			
30. Drug and / or alcohol problems			
31. Verbal, physical and / or sexual abuse (as an abuser or as a victim)			
32. Other behaviors of concern:			

Family Social History

Is the family now experiencing any of the following difficulties or adjustments?	Yes	No	Not Sure
33. Parental marriage problems, separation, or divorce			
34. Child-custody dispute			
35. No members of extended family (grandparents, aunts, uncles, cousins)living in area			
36. No close friends of the family living in the area			
37. Child has no good playmates in the neighborhood			
38. Stressful living situation (e.g. too many daily "hassles", financial worries, legal problems)			
39. Discipline problems with other children in the family			
40. Unsafe neighborhood or community			
41. Sudden, serious illness or injury: long term illness; violence to, or death of family member			
42. Other important event(s):			

RELATIONSHIPS

***Please place an (x) on any items that apply* to your child.**

_____ Too few friends
_____ Regularly talks/plays with friends
_____ Is overly shy
_____ Makes friends easily
_____ Others seem to be picking on my child
_____ Plays mostly with younger children
_____ Has enough friends
_____ Often gets into fights with friends
_____ Withdrawing from friends
_____ Finds it hard to keep friends
_____ Bullying or mean to friends
_____ Hangs out with a "bad" crowd

SOURCES OF STRESS

Please list the things/events/problems that are creating stress for your child at the present time.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

CURRENT FUNCTIONING

Place and (x) on the following scale to indicate how well your child is coping with things at the present time. 100% means your child is coping the best he or she ever has.

_____

0 10 20 30 40 50 60 70 80 90 100

YOUR CHILD'S GOALS IN COUNSELING

Please list the goals that you hope your child will achieve in counseling. (Be as specific as you can.)

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____

HOW MANY SESSIONS DO YOU THINK YOUR CHILD WILL NEED?

Please place an (x) in the answer which best describes your expectations.

_____ 1 – 3 session _____ 4 – 6 sessions _____ 7 – 9 sessions _____ 10 – 12 sessions _____ 12 – 14 sessions

_____ Other (please specify how many _____sessions.

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Child's Name: _____ Date: _____

Below is a series of phrases that describe children's behaviors. Please circle the number (1-7) tat describes **HOW OFTEN** your child is showing the behavior indicated. Also, please circle **"YES"** if the child's behavior indicated is a problem for you.

	Never	Seldom		Sometime	Often		Always	A Problem for you?
1. Dawdles in getting dressed	1	2	3	4	5	6	7	Yes
2. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	Yes
3. Has poor table manners	1	2	3	4	5	6	7	Yes
4. Refuses to eat food presented	1	2	3	4	5	6	7	Yes
5. Refuses to do chores when asked	1	2	3	4	5	6	7	Yes
6. Slow in getting ready for bed	1	2	3	4	5	6	7	Yes
7. Refuse to go to bed on time	1	2	3	4	5	6	7	Yes
8. Does not obey house rules on his/her own	1	2	3	4	5	6	7	Yes
9. Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	Yes
10. Acts defiant when told to do something	1	2	3	4	5	6	7	Yes
11. Argues with parents about rules	1	2	3	4	5	6	7	Yes
12. Gets angry when does not get his/her own way	1	2	3	4	5	6	7	Yes
13. Has temper tantrums	1	2	3	4	5	6	7	Yes
14. Sasses adults	1	2	3	4	5	6	7	Yes
15. Whines	1	2	3	4	5	6	7	Yes
16. Cries easily	1	2	3	4	5	6	7	Yes
17. Yells or screams	1	2	3	4	5	6	7	Yes
18. Hits parents	1	2	3	4	5	6	7	Yes
19. Destroys toys or other objects	1	2	3	4	5	6	7	Yes
20. Is careless with toys and other objects	1	2	3	4	5	6	7	Yes
21. Steals	1	2	3	4	5	6	7	Yes
22. Lies	1	2	3	4	5	6	7	Yes
23. Teases and provokes other children	1	2	3	4	5	6	7	Yes
24. Verbally fights with friends	1	2	3	4	5	6	7	Yes
25. Verbally fights with brothers and/or sisters	1	2	3	4	5	6	7	Yes
26. Physically fights with friends his/her own age	1	2	3	4	5	6	7	Yes
27. Physically fights with brothers and/or sisters	1	2	3	4	5	6	7	Yes
28. Constantly seeks attention	1	2	3	4	5	6	7	Yes
29. Interrupts	1	2	3	4	5	6	7	Yes
30. Is easily distracted	1	2	3	4	5	6	7	Yes
31. Has short attention span	1	2	3	4	5	6	7	Yes
32. Fails to finish tasks or projects	1	2	3	4	5	6	7	Yes
33. Has difficulty entertaining self when alone	1	2	3	4	5	6	7	Yes
34. Has difficulty concentrating on one thing	1	2	3	4	5	6	7	Yes
35. Is overactive or restless	1	2	3	4	5	6	7	Yes
36. Wets the bed	1	2	3	4	5	6	7	Yes