WESTERN WISCONSIN HEALTH

Western Wisconsin Health MENTAL HEALTH CHILD MEDICAL QUESTIONNAIRE – Ages Thirteen (13) – Seventeen (17)

Childs Name:	Birthdate:	Today's Date:
Primary Care Physician:		Medical Clinic:
Address/City/State/Zip:		Clinic Telephone:
1. May we contact your Physician?: (H	Please Circle) YES	NO
2. When was the last time you saw yo	ur physician?: (Date)	
3. What medical problems did you see		
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	-	er-the counter medications as well as herbal supplements:
		or 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 illnes	s in your family?: (Please	Circle) YES NO If yes, please describe:
		e Circle) YES NO If so, please list with whom, dates s and outcome of treatment.:
11. Please list any hospitalizations, se	rious illnesses, or operation	ons including dates and where treated:
		learning disability or other perceptual deficit/impairment?
13. Does your child use alcohol or dru How Long?:	ıgs? (Please Circle) YES Week	NO Type Used:
Outcome of treatment:		ms (Please Circle): YES NO When, Where, and
15. Is there any family history of drug	s or alcohol problems?: _	
		ould be helpful for us to know?:

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:	Home Phone:
Work Phone:	Work Phone:
Cell 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:
	\Box Far Below Grade \Box Below Grade \Box At Grade \Box Above Grade
Has the child been evaluated for any special	If yes, does the child have an Individual Education Plan
needs by the school? \Box Yes \Box No	(IEP) in force? \Box Yes \Box No

Child's Physician

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:	Office Phone:
Fax Phone:	Fax Phone:
Did the Physician refer the child? \Box Yes \Box No	Did the therapist refer the child? \Box Yes \Box No
If no, may we contact the physician? \Box Yes \Box No	

Western Wisconsin Health MENTAL HEALTH CHILD MEDICAL QUESTIONNAIRE – Ages Thirteen (13) – Seventeen (17) PROBLEMS THAT YOUR TEEN IS HAVING

Please use an (x) to indicate which problems apply to your teen at this time.

Depression	Communication problems
Suicidal thoughts or actions	Low self-esteem
Anxiety/Worries/Moody	Physically abused when younger
Fights often/verbal/physical	Sexually abused when younger
Temper outbursts/explosive	Sexual problems
Alcohol/other drug abuse (by teen)	Violence in the family (actual or threatened)
School problems	Family problems
Truancy/won't go to school	Conflicts with mother (or step-mother)
Kicked out/expelled from school	Conflicts with father (or step-father)
Learning disabilities	Remarried family problems
Trouble paying attention	Parents having marital problems
Not getting work don	Problems with brother/sister
Not listening to teacher	Running away from home
Fighting at school	Very sassy or disobedient
Financial problems (in family)	Too much yelling or screaming
Death of a loved one	Bed wetting/soiling pants
Major losses/difficult changes	Setting fires
Frequent stealing, lying or cheating	Too shy (clingy/afraid to leave parents)
Diagnosed as hyperactive	Restless/doesn't think before acing
Problems with friends	Other

ANY PROBLEMS WITH COPING

Please use an (x) to indicate which of the following problems apply to your teen.

Sleep problems	Change in appetite
Difficulty falling asleep	Gaining weight (how much)
Waking up in the middle of the night	Losing weight (how much)
Waking up too early	Not hungry
Sleeping too much	Throwing up after eating
Nightmares	Feeling sick to stomach
Moody or crying more than usual	Constipation or diarrhea
Feeling guilty, worthless, or hopeless	Difficulties concentrating
Fatigue/low energy	Problems remembering things
Hyper/too much energy	Withdrawing from others
Loss of interest	Repeated actions that child can't stop
Disturbing thoughts child can't stop	Can't stop washing hands/body, counting or checking things
Believes people are out to get him/her	Believes people are picking on him/her
Other (please specify)	

MEDICAL HISTORY

Please use an (x) to indicate the following medical conditions your teen now has or has had in the past.

1. Chronic Medical Conditions/Serious Illnesses (if none apply place an (x) on "None")

None	Asthma	Diabetes	Ulcers
Epilepsy	Seizures	Lupus	Stroke
Cancer	Heart Condition	Multiple Sclerosis	Headaches
Thyroid	Headaches	Previous Head Injury	
Gynecological Problems Other ((specify)	
Allergies or Drug Sensitivities?			

2. Previous Hospitalizations/Surgeries (If none, write "None")

Date	Reason

3. List any Previous Suicide Attempts (If none, write "None")

When	What Method

4. Current Prescriptions/Medications

Type of Medication	Dosage	Morning	Evening	Bedtime

5. Family History – Any Major Health Problems or Drug/Alcohol Use: _____

6. **Development History**

Please use an (x) to all that apply.

- _____ Difficult pregnancy/labor, deliver
- _____ Problems with health, feeding and
- or sleeping during first year of life
- _____ Frequent ear infections

_____ Other problems (please specify) ______

- _____ Speech or hearing problems _____ Slow in learning to sit up, crawl, walk,
 - _____ Slow in learning to sit up, clawi,
 - feed self, dress self
- _____ Frequent headaches, stomach aches, nausea other pains

7. Family History of Mental Health

Please place an (x) to indicate following conditions and who has had a history of illness.

Schizophrenia (Who?)	
Manic-Depressive Disorder (Who?)	
Major Depression (Who?)	
Alcoholism (Who?)	
Anxiety Disorder (Who?)	
Other Emotional Problems or Mental Illness (Who?)	

PREVIOUS COUNSELING

Name of Therapist or Agency/Phone Number	Purpose/Outcome

LIFESTYLE CHOICES

Please place an (x) on any item to the best of your knowledge regarding your teen.

_____ Smoking (how much?) _____

Alcohol use (how much and how frequently?)

Other Drug Use (which ones and how much?)

____ Coffee/Tea/Pop (which ones and how much?) _____

Has your teen had any police contact or legal charges? If so, complete below (if not, write "None")

When	What Charges?	i

Are there any guns or weapons in the house?

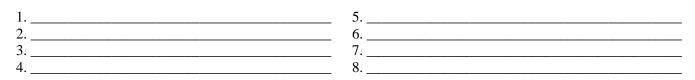
RELATIONSHIPS

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

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

SOURCES OF STRESS

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



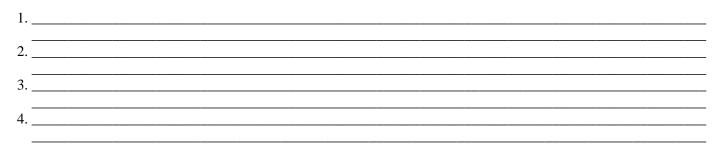
CURRENT FUNCTIONING

Place and (x) on the following scale to indicate how well your teen is coping with things at the present time. 100% means your teen 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 teen will achieve in counseling. (Be as specific as you can.)



HOW MANY SESSIONS DO YOU THINK YOUR TEEN 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.

Teen Medical Questionnaire 6/16