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?: (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

PROBLEMS THAT YOUR TEEN IS HAVING

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

_____ Depression
_____ Suicidal thoughts or actions
_____ Anxiety/Worries/Moody
_____ Fights often/verbal/physical
_____ Temper outbursts/explosive
_____ Alcohol/other drug abuse (by teen)
_____ School problems
  _____ Truancy/won't go to school
  _____ Kicked out/expelled from school
  _____ Learning disabilities
  _____ Trouble paying attention
  _____ Not getting work don
  _____ Not listening to teacher
  _____ Fighting at school
_____ Financial problems (in family)
_____ Death of a loved one
_____ Major losses/difficult changes
_____ Frequent stealing, lying or cheating
_____ Diagnosed as hyperactive
_____ Problems with friends

_____ Communication problems
_____ Low self-esteem
_____ Physically abused when younger
_____ Sexually abused when younger
_____ Sexual problems
_____ Violence in the family (actual or threatened)
_____ Family problems
  _____ Conflicts with mother (or step-mother)
  _____ Conflicts with father (or step-father)
  _____ Remarried family problems
  _____ Parents having marital problems
  _____ Problems with brother/sister
  _____ Running away from home
  _____ Very sassy or disobedient
_____ Too much yelling or screaming
_____ Bed wetting/soiling pants
_____ Setting fires
_____ Too shy (clingy/afraid to leave parents)
_____ Restless/doesn't think before acing
_____ Other _____

ANY PROBLEMS WITH COPING

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

_____ Sleep problems
  _____ Difficulty falling asleep
  _____ Waking up in the middle of the night
  _____ Waking up too early
  _____ Sleeping too much
  _____ Nightmares
_____ Moody or crying more than usual
_____ Feeling guilty, worthless, or hopeless
_____ Fatigue/low energy
_____ Hyper/too much energy
_____ Loss of interest
_____ Disturbing thoughts child can't stop
_____ Believes people are out to get him/her

_____ Change in appetite
  _____ Gaining weight (how much _____)
  _____ Losing weight (how much _____)
  _____ Not hungry
  _____ Throwing up after eating
  _____ Feeling sick to stomach
_____ Constipation or diarrhea
_____ Difficulties concentrating
_____ Problems remembering things
_____ Withdrawing from others
_____ Repeated actions that child can't stop
_____ Can't stop washing hands/body, counting or checking things
_____ 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
_____ Speech or hearing problems
_____ Slow in learning to sit up, crawl, walk, feed self, dress self
_____ Frequent headaches, stomach aches, nausea other pains

_____ Other problems (please specify) _____
_____

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?

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
_____ 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 teen 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 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.)

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

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.