



FAMILY COUNSELING SERVICES

MENTAL HEALTH QUESTIONNAIRE

Desert View Healthy Kids Program

Child's Name: _____ Date of Birth: _____
Managed Care Organization: _____ Child's Medicaid #: _____

Ages 13 – 20 years

Check all answers that may apply. This form may be filled out by the patient, parent/guardian or health care provider.

Do you have trouble paying attention? Yes No

Do you often:

Feel distrustful of others Yes No

Have strange thoughts Yes No

Hear voices Yes No

Have to do things the same way or keep repeating them..... Yes No

Do you have problems at school with?

Behavior Yes No

Grades Yes No

Skipping classes Yes No

Do you worry about your:

Eating Yes No

Sleep Yes No

Weight Yes No

Do you have trouble making or keeping friends? Yes No

Do you often feel?

Sad Yes No

Angry Yes No

Nervous or afraid Yes No

Have you thought about or done any of the following:

Destroy property Yes No

Hurt animals Yes No

Set fire..... Yes No

Listen to music with violent message Yes No

Use alcohol..... Yes No

Use drugs Yes No

Smoke cigarettes Yes No

Sex without protection..... Yes No

Suicide attempt Yes No

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Is there a history of injuries, accidents? Yes No
If yes, please specify: _____

Is there any history of maltreatment or abuse? Yes No
If yes, please specify: _____

Is there a recent stress on the family or child such as?

- Birth of a child Yes No
Moving Yes No
Divorce or separation Yes No
Death of a close relative..... Yes No
Fired or laid off Yes No
Legal problems Yes No
Others (Please specify): _____ Yes No

Do you have other parenting concerns? Yes No
Please specify: _____

Provider: Please give additional information that may be helpful to the therapist.

Parent's Signature: _____

Date _____

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____

Child's Address: _____

Child's Phone: _____

Referred to: _____

Reason for Referral: _____

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