WHERE FAMILIES COME FIRST
Desert View
FAMILY COUNSELING SERVICES

Mental Health Questionnaire

Desert View Healthy Kids Program

Child's Name:_____ Date of Birth:_____

Managed Care Organization:_____ Child's Medicaid #:_____

Ages 10-12 years

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

Does your child have trouble paying attention?	☐ Yes	☐ No
Does your child often seem:		
Distrustful of others	☐ Yes	☐ No
To express strange throughts	☐ Yes	☐ No
Blame others	☐ Yes	☐ No
Does your child have problems at school with?		
Behavior	☐ Yes	☐ No
Grades	☐ Yes	☐ No
Skipping classes	☐ Yes	☐ No
Do you have concerns about your child's?		
Eating	☐ Yes	☐ No
Sleep	☐ Yes	☐ No
Weight	☐ Yes	☐ No
Does your child often complain of "not feeling well"?	☐ Yes	☐ No
Does your child have trouble making or keeping friends?	☐ Yes	☐ No
Does your child often seem:		
Sad	☐ Yes	☐ No
Angry	☐ Yes	☐ No
Nervous or afraid	☐ Yes	☐ No
Does your child show any of this behavior:		
Destroy Property	☐ Yes	☐ No
Set Fire	☐ Yes	☐ No
Lie	☐ Yes	☐ No
Steal	☐ Yes	☐ No
Listen to music with violent messages	☐ Yes	☐ No
Hurt animals or smaller children	☐ Yes	☐ No
Use Alcohol	☐ Yes	☐ No
Use Drugs	☐ Yes	☐ No
Smoke cigarettes	☐ Yes	☐ No
Sexually active	☐ 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 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

If yes, please specify: _____

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

_____

_____

_____

_____

_____ _____

Parent/Guardian(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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