WHERE FAMILIES COME FIRST

Desert View

FAMILY SERVICES & COUNSELING

Mental Health Questionnaire

Desert View Healthy Kids Program

Name:_____ Date of Birth:_____

Managed Care Organization:_____ Medicaid #:_____

Ages 13-20 years

Check all answers that may apply. This form may be filled out by the 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 messages	☐ 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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Desert View Healthy Kids Program

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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 you or the family 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 concerns? ..... ☐ Yes ☐ No

If yes, please specify: _____

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

_____

_____

_____

_____

_____ _____

Provider/Parent/Guardian(s) Signature **Date**

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Provider Receiving Referral: _____

Provider's Address: _____

Provider's Phone:_____

Referred to: _____

Reason for Referral: _____

Desert View Healthy Kids Program
Desert View Family Counseling Services