

**Baldwin Area Medical Center /Northwest Counseling Services**  
**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: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____

**Person(s) living with child (brothers, sisters, relatives, friends)**

Name: _____	Age: _____	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Step-Sister	<input type="checkbox"/> Step-Brother	<input type="checkbox"/> Other
Name: _____	Age: _____	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Step-Sister	<input type="checkbox"/> Step-Brother	<input type="checkbox"/> Other
Name: _____	Age: _____	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Step-Sister	<input type="checkbox"/> Step-Brother	<input type="checkbox"/> Other
Name: _____	Age: _____	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Step-Sister	<input type="checkbox"/> Step-Brother	<input type="checkbox"/> Other
Name: _____	Age: _____	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Step-Sister	<input type="checkbox"/> Step-Brother	<input type="checkbox"/> Other
Name: _____	Age: _____	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Step-Sister	<input type="checkbox"/> Step-Brother	<input type="checkbox"/> 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: <input type="checkbox"/> Far Below Grade <input type="checkbox"/> Below Grade <input type="checkbox"/> At Grade <input type="checkbox"/> Above Grade
Has the child been evaluated for any special needs by the school? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, does the child have an Individual Education Plan (IEP) in force? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, may we contact the physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the therapist refer the child? <input type="checkbox"/> Yes <input type="checkbox"/> No

**PROBLEMS THAT YOUR TEEN IS HAVING**

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

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

**ANY PROBLEMS WITH COPING**

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

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

- |   |  |   |                                    |
|---|--|---|------------------------------------|
| <input type="checkbox"/> None                                   | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Ulcers    |
| <input type="checkbox"/> Epilepsy                               | <input type="checkbox"/> Seizures              | <input type="checkbox"/> Lupus                | <input type="checkbox"/> Stroke    |
| <input type="checkbox"/> Cancer                                 | <input type="checkbox"/> Heart Condition       | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Thyroid                                | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Previous Head Injury |                                    |
| <input type="checkbox"/> Gynecological Problems                 | <input type="checkbox"/> Other (specify) _____ |   |                                    |
| <input type="checkbox"/> 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.*

- |  |   |
|--|---|
| <input type="checkbox"/> Difficult pregnancy/labor, deliver                                      | <input type="checkbox"/> Speech or hearing problems                                     |
| <input type="checkbox"/> Problems with health, feeding and or sleeping during first year of life | <input type="checkbox"/> Slow in learning to sit up, crawl, walk, feed self, dress self |
| <input type="checkbox"/> Frequent ear infections   | <input type="checkbox"/> Frequent headaches, stomach aches, nausea other pains          |
| <input type="checkbox"/> 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.*

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>_____ Too few friends</li> <li>_____ Regularly talks/plays with friends</li> <li>_____ Is overly shy</li> <li>_____ Makes friends easily</li> <li>_____ Others seem to be picking on my child</li> <li>_____ Plays mostly with younger children</li> </ul> | <ul style="list-style-type: none"> <li>_____ Has enough friends</li> <li>_____ Often gets into fights with friends</li> <li>_____ Withdrawing from friends</li> <li>_____ Finds it hard to keep friends</li> <li>_____ Bullying or mean to friends</li> <li>_____ Hangs out with a “bad” crowd</li> </ul> |
|---|---|

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**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.