Initial Clinical Questionnaire

[In this questionnaire "child" refers to kids of all ages, infant to 21 years.]

Child's Name: _____ Age: _____ Gender: [ ] M, [ ] F
Your Name & Relationship: _____ Today's Date: _____
Address: _____
Phone numbers: _____
Primary Care Physician (child's): _____
Therapist (list any from the past year): _____ [ ] current
From whom did you get my name? _____. What is that person's relationship to you? _____
Insurance (Health) Coverage: _____ Through what employer: _____
ID #: _____ Group #: _____
Ethnicity: _____

1. Are there concerns about suicide risk? [ ] no, [ ] yes; explain: _____
_____.
2. Are there concerns about violence toward others (toward whom)? [ ] no, [ ] yes; explain:
_____.
3. Is this assessment needed primarily for a legal matter (e.g., related to a custody decision or a civil suit)? [ ] no, [ ] yes: _____.

[Note: I do not do forensic evaluations.]

3. Does your child have a specific diagnosis (es) for this problem? [ ] no, [ ] yes; explain:
_____.
4. Name all the other diagnoses which have been considered and questioned: _____
_____.
5. Is he/she missing school or work due to this problem? [ ] no, [ ] yes; explain: _____
_____.
6. Are there known or suspected psychotic symptoms (e.g. hallucinations, delusions, or very bizarre behavior)? [ ] no, [ ] yes; explain: _____
_____.
7. Are there concerns about Substance Abuse? [ ] no, [ ] yes; explain: _____
_____.
8. Are there serious current or chronic general health or medical problems? [ ] no, [ ] yes; explain:
_____.
9. Is there a known or suspected developmental delay, intellectual disability ("mental retardation"), or Autism Spectrum Disorder? [ ] no, [ ] yes; explain: _____
_____.
10. Are other agencies involved? [ ] no, [ ] yes:
[ ] IEP at School; [ ] 504 at School; [ ] Juvenile Justice; [ ] County Developmental Disabilities; [ ] Child Protective Services/Child Welfare (DHS); [ ] Other: _____.
11. Is your child currently taking medication for an emotional or behavioral problem? [ ] no, [ ] yes (please **<u>list the daily dosage</u>** for each medication): _____
_____.
12. Has your child had prior intensive treatment? [ ] no, [ ] yes: _____.
[ ] Inpatient; [ ] Residential; [ ] Day Hospital; [ ] Day Treatment; [ ] Other: _____.