KIDSENSE THERAPY GROUP

MENTAL HEALTH QUESTIONNAIRE

INSTRUCTIONS: PLEASE COMPLETE AND RETURN THIS FORM PRIOR TO YOUR FIRST VISIT.

Child's Name: _____

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No ☐ Yes, previous therapist/practitioner: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your child's current physical health? (please check)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems your child is currently experiencing:

How would you rate your child's current sleeping habits? (Please check)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

How many times per week does your child generally socialize? _____

What types of socializing do they participate in? _____

Please list any difficulties your child experiences with appetite or eating patterns.

Is your child currently experiencing overwhelming sadness, grief or depression?

☐ No ☐ Yes If yes, for approximately how long? _____

Is your child currently experiencing anxiety, panic attacks or have any phobias?

☐ No ☐ Yes If yes, when did they begin experiencing this? _____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you/ your child in the space provided (father, grandmother, uncle, etc.).

Please Check if Applicable & List Family Member

- ☐ Alcohol/Substance Abuse _____
- ☐ Anxiety _____
- ☐ Depression _____
- ☐ Domestic Violence _____
- ☐ Eating Disorders _____
- ☐ Obesity _____
- ☐ Obsessive Compulsive Behavior _____
- ☐ Schizophrenia _____
- ☐ Suicide Attempts _____

What do you consider to be some of your child's strengths?

What do you consider to be some of your child's weaknesses?

Person completing form: _____

Relationship to client: _____ Date: _____