Mankato Mental Health Associates

201 North Broad Street, Suite 308
Mankato, MN 56001-3569
507-345-4448

INTAKE QUESTIONNAIRE (CHILD/ADOLESCENT)

The following questionnaire is designed to assist you and me in developing and carrying out the type of services which seems most appropriate for you.

If you don't wish to answer a question or if it doesn't apply to you, simply write the letters **NA** (Not Applicable). If you don't know or can't remember, write the letters **DK** (Don't Know).

Please remember that this document, like all others in your file, is confidential and cannot be released without your written consent.

1. GENERAL INFORMATION

Full Name_____Today's Date_____

Who suggested you contact us_____

Describe your reason(s) for seeking assistance

When did these issues become a problem?

What have you already tried? What was the result?

2. OCCUPATIONAL/EDUCATIONAL/RECREATIONAL INFORMATION

Highest grade completed/current grade_____School_____

Grades in school are: ☐Excellent ☐Good ☐Fair ☐Poor

Have you had problems with: ☐Learning ☐Behavior ☐Teachers ☐Classmates

Do you have an IEP or 504 plan?_____

Favorite subjects_____Least favorite subjects_____

Current job_____Number of years there_____

Previous work_____

What do you do with your free time?_____

Do you have many friends or social groups?_____

3. **FAMILY**

Mother's name:_____Age:_____

Occupation:_____Marital status:_____

Father's name:_____Age:_____

Occupation:_____Marital status:_____

Parents' marital status: _____

Number of siblings and ages:_____

Currently live with:_____

Have you been:

Happy with the way you were raised?	YES	NO
Treated cruelly, beaten, or mistreated?	YES	NO
Sexually abused?	YES	NO

Is there a history of any of the following in your family?

☐Anxiety
☐Depression
☐Addiction
☐Eating disorder
☐Learning disorder
☐Bipolar disorder
☐Schizophrenia
☐ADHD
☐Suicide

What was the pregnancy with you like?_____

_____

Was there anything unusual about your birth?	YES	NO
Did your mother drink, smoke, or use drugs while pregnant with you?	YES	NO
Were there any medical difficulties for you when you were an infant?	YES	NO

If yes, what?_____

Did you experience any accidents causing injury to you?	YES	NO

If yes, what?_____

4. **MEDICAL INFORMATION**

Name of primary physician and clinic_____

Date of most recent physical exam_____

Surgeries_____

Hospitalizations_____

Head injuries_____

Allergies_____

Are you currently suffering from any medical conditions? YES NO

If so, what conditions_____

On any medications?_____

How good is your sleep each night? _____

How many hours of sleep do you get?_____

How many times a day do you eat a meal?_____

How many times a day do you eat fruits/vegetables? _____

How much physical activity do you get each day?_____

5. **MENTAL HEALTH INFORMATION**

Have you ever had mental health treatment? YES NO

If so, please list names of therapists, dates of therapy, and which agencies you've used

_____

_____

Have you ever been hospitalized for a mental health problem? YES NO

If so, please list dates and hospitals_____

_____

Are you currently taking a medication for mental health reasons? YES NO

If so, please list the medication name(s) and dosage(s)_____

_____

Prescriber of medication(s)_____

Any past mental health medications?_____

6. LEGAL HISTORY

Have you ever been:

☐On probation ☐In jail ☐In prison ☐On parole

If so, when and why?_____

7. CHEMICAL USE HISTORY

Have you ever been treated for drug or alcohol abuse? YES NO

If so, where?_____When_____

	Current Amount Used	Past Use	Age First Used
Caffeine			
Tobacco			
Alcohol			
Marijuana			
Other			
Other			

Drug of choice (if any)_____

	YES	NO
Have you used more than one chemical at the same time in order to get high?	☐	☐
Do you avoid family activities so you can use?	☐	☐
Do you have a group of friends who also use?	☐	☐
Do you use to improve your emotions such as when you feel sad or depressed?	☐	☐

8. RELIGION/SPIRITUALITY

Religious or spiritual identity:_____

Are you actively practicing? YES NO

9. OTHER IMPORTANT INFORMATION

Is there anything else important you feel we should know about who you are?

_____

_____

_____

_____

_____

_____

10. SYMPTOM REVIEW

Please check any of the following that have applied to you in the past two weeks. Use a question mark if you're not sure.

- ☐ Make careless mistakes
- ☐ Difficulty sustaining attention
- ☐ Don't appear to listen when spoken to
- ☐ Fail to finish tasks
- ☐ Easily distracted
- ☐ Bad organizing
- ☐ Forgetful
- ☐ Tend to lose things
- ☐ In school, leave seat often
- ☐ Run and climb too much
- ☐ Often fidget
- ☐ Avoid sustained mental effort
- ☐ Loud when playing
- ☐ Very talkative
- ☐ Interrupt and intrude a lot
- ☐ Difficulty waiting turn
- ☐ Often angry or irritable, easily annoyed
- ☐ Bad temper
- ☐ Blame others for own mistakes
- ☐ Touchy
- ☐ Argue with adults
- ☐ Talk back often
- ☐ Resentful/vindictive
- ☐ Do things to annoy others
- ☐ Often sad
- ☐ Too few friends
- ☐ Withdrawn
- ☐ Low interest in activities
- ☐ Tiredness/fatigue
- ☐ Large change in appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Feel hopeless
- ☐ Sleep problems
- ☐ Cry often and easily
- ☐ Many physical complaints
- ☐ Difficulty making decisions
- ☐ Talk about death a lot
- ☐ Thinking about hurting/killing self
- ☐ Talking about hurting/killing self
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Severe headaches
- ☐ Chronic pain
- ☐ High blood pressure
- ☐ Seizures
- ☐ Sleep walking
- ☐ Dizziness
- ☐ Nail biting
- ☐ Skin picking
- ☐ Tics
- ☐ Often daydreaming
- ☐ Confused about identity
- ☐ Odd/strange behavior
- ☐ Repeated actions I can't stop
- ☐ Repeated thoughts I can't stop
- ☐ Unable to relax
- ☐ Nightmares
- ☐ Worry often
- ☐ Overly shy
- ☐ Stubborn
- ☐ Tense
- ☐ Submissive
- ☐ Show off/center of attention
- ☐ Follower
- ☐ See things others don't
- ☐ Hear things others don't
- ☐ Easily embarrassed
- ☐ Clumsy/careless
- ☐ Don't like self
- ☐ Eat non-food items
- ☐ Use drugs/alcohol
- ☐ Fearful
- ☐ Bedwetting
- ☐ Worries about leaving family
- ☐ Refuses to go to school
- ☐ Refuses to sleep alone
- ☐ Skips school
- ☐ Destructive of property
- ☐ Swear/use bad language often
- ☐ Light fires
- ☐ Often lies
- ☐ Mean to animals
- ☐ Steal

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Circle to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

CES

Below is a list of some ways you may have felt or behaved. Please indicate how often you have felt this way during the last week by circling the appropriate number. Please only provide one answer to each question.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days
1. I was bothered by things that usually don't bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4. I felt I was just as good as other people.	0	1	2	3
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	0	1	2	3
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	0	1	2	3
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	0	1	2	3
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people disliked me.	0	1	2	3
20. I could not get going.	0	1	2	3