Pediatric Mental Health Questionnaire

PATIENT INFORMATION **Allergies:** ________ **Weight:** _________ **Date:** ___________

Patient Information	*First Name* *Middle Name* *Last Name* *Date of Birth* *Height* *Age*
Grade/School	
Home Mail Address	*Street* *Apt.* *City* *State* *Zip Code*
Mother's Information	*Name* *Occupation* *Home Phone* *Cell/Work Phone* *Email Address*
Father's Information	*Name* *Occupation* *Home Phone* *Cell/Work Phone* *Email Address*

REFERRED BY

____

CURRENT/ON-GOING PROBLEMS

Why are you coming in for help at this particular time? ____________________

____

____

____

____

Please List all current and ongoing problems and diagnoses in order of priority:

Describe Problem	*Mild*	*Moderate*	*Severe*	*Prior Treatment/Approach*	*Excellent*	*Good*	*Fair*

When did you first notice problems? ____

____

____

____

____

____

Pediatric Mental Health Questionnaire

FOOD HISTORY

Typical Breakfast	
Typical Lunch	
Typical Dinner	
Snacks	
Favorite Foods	
Food Intolerances	

GENERAL QUESTIONS

What does your child do for exercise?

Please describe: ____

____

____

____

What kind of activities and hobbies does your child enjoy?

Please describe: ____

____

____

Does your child do well in sports and have good gross motor skills?

Please describe: ____

____

____

Does your child have good handwriting and fine motor skills?

Please describe: ____

____

____

Has your child experienced any major life changes or losses that may have impacted his or her health? ☐ *Yes* ☐ *No*

If yes please describe: ____

____

____

Have you ever sought counseling for your child or family? ☐ *Yes* ☐ *No*

If yes please describe: ____

____

____

Has your child ever been abused or been a victim of crime? ☐ *Yes* ☐ *No*

If yes please describe: ____

____

____

Pediatric Mental Health Questionnaire

Does your child seem stressed to you?	☐ *Yes* ☐ *No*
If yes please describe: ______	
Has your child previously used illicit drugs?	☐ *Yes* ☐ *No*
If yes please describe: ______	
Do you suspect that your child may be using illicit drugs?	☐ *Yes* ☐ *No*
If yes please describe: ______	
Does your child get along well with friends and family members?	☐ *Yes* ☐ *No*
*If **no** please describe:* ______	
Does your child sleep well?	☐ *Yes* ☐ *No*
*If **no** please describe:* ______	
How may hours does your child sleep per night?	
Does your child snore?	☐ *Yes* ☐ *No*
How much screen time (computer, TV, etc.) does your child have per day?	
How much time does your child spend on video games per day?	

SCHOOL HISTORY

Is your child in special education class currently?	☐ *Yes* ☐ *No*
If yes please describe: ______	
Has your child ever received special help in school or tutoring?	☐ *Yes* ☐ *No*
If yes please describe: ______	
Is your child considered a behavior problem at school or at home?	☐ *Yes* ☐ *No*
If yes please describe: ______	

Has your child ever been evaluated for learning disabilities?	☐ *Yes* ☐ *No*
If yes please describe: ______	

Is your child able to complete his or her homework on time?	☐ *Yes* ☐ *No*
*If **no** please describe:* ______	

What kind of grades does your child usually get?
______

Is your child at:

	Grade Level	Below Grade Level	Advanced
Reading			
Spelling			
Writing			
Math			

ADHD TRAITS EVALUTION

Please check the box if any of these statements describe your child:

ADHD Predominantly Inattentive Type (ADHD-I):	
☐	*Fails to give close attention to details or makes careless mistakes*
☐	*Has difficulty sustaining attention*
☐	*Does not appear to listen*
☐	*Struggles to follow through on instructions*
☐	*Has difficulty with organization*
☐	*Avoids or dislikes tasks requiring sustained mental effort*
☐	*Loses things*
☐	*Is easily distracted*
☐	*Is forgetful in daily activities*

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ADHD Predominantly Hyperactive-Impulsive Type (ADHD-HI):	
☐	*Fidgets with hands or feet or squirms in chair*
☐	*Has difficulty remaining seated*
☐	*Runs about or climbs excessively*
☐	*Difficulty engaging in activities quietly*
☐	*Acts as if driven by a motor*
☐	*Talks excessively*
☐	*Blurts out answers before questions have been completed*
☐	*Difficulty waiting or taking turns*
☐	*Interrupt or intrudes upon others.*

ADHD Combined Type (ADHD-C):	
☐	*Individual meets both sets of inattention and hyperactive/impulsive criteria*

Under/Over Methylation *Please check any boxes that apply.*

Under Methylation		Over Methylation	
☐	Seasonal Allergies	☐	Chemical and Food Sensitivities
☐	Perfectionism	☐	Under-achiever
☐	Competitiveness	☐	Upper Body Pain
☐	Obsessive-Compulsive Tendencies	☐	Adverse Reaction to SSRI Medication (Prozac, Paxil, Zoloft, St. John's Wort)
☐	Highly Motivated	☐	Dry Eyes
		☐	Self-Injury
		☐	High Artistic/Musical Ability

Left Brian/Right Brain Characteristics *Please check any boxes that apply.*

Right Brain		Left Brain	
☐	Visual	☐	Demonstrates Logical Thinking
☐	Spontaneous	☐	Good with Detail
☐	Likes to be Shown how to do a Task Rather then be Told	☐	Memorizes Easily
☐	Solves Problems by Looking at Similarities and Patterns Rather than Differences	☐	Good at Math
☐	Would Rather Draw than Write	☐	Thinks in Words
☐	Thinks in Pictures	☐	Assimilates Information by Looking at the Pieces before Looking at the Whole
☐	Assimilates Whole Chunks of Information before Breaking Down the Information into Discrete Pieces	☐	Solves problems by Looking at Differences Rather than Similarities

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Pyroluria – Please check any boxes that apply.			
☐	Poor Stress Control	☐	Poor Short Term Memory
☐	Fearfulness	☐	Sensitivity to Loud Noises
☐	Sensitivity to Bright Lights	☐	Like Spicy and Salty Foods
☐	Morning Nausea	☐	Pale Skin/Inability to Tan
☐	Tendency to Skip Breakfast	☐	Has Delicate Facial Features
☐	High Irritability and Temper	☐	Extreme Mood Swings
☐	History of Under Achievement	☐	Severe Inner Tension
☐	Little or No Dream Recall	☐	Poor Muscle Development
☐	Auto Immune Disorders	☐	Delayed Growth
☐	Delayed Puberty	☐	Fruity Breath and/or Body Odor
☐	Frequent Infections	☐	Tendency to Stay Up Very Late
☐	Mauve or Dark Colored Urine	☐	History of a Reading Disorder

MEDICAL HISTORY

Blood Type – Please check applicable box.			
☐	A	☐	B
☐	AB	☐	O
☐	Don't Know		

PREVIOUS EVALUATIONS check box if yes and provide year

☐		Full Physical Exam	☐		Psychological Evaluations
☐		WPPSI or WISC-R for Intelligence	☐		Speech and Language Evaluations
☐		Genetic Evaluation	☐		Neurological Evaluations
☐		Gastroenterology Evaluations	☐		Other Injuries
☐		Celiac/Gluten Testing	☐		Auditory Evaluation
☐		Allergy Evaluation	☐		Vision Testing
☐		Nutritional Evaluation	☐		Labs (Please provide copies of results)
☐		X-rays or Scans			

HOSPITALIZATIONS/INJURIES/SURGERIES

Date	Describe

Pediatric Mental Health Questionnaire

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset for any of these conditions if applicable.*

	Date	GASTROINTESTINAL
☐		Irritable Bowel Syndrome
☐		Inflammatory Bowel Disease
☐		Crohn's
☐		Ulcerative Colitis
☐		GERD (reflux)
☐		Celiac Disease
☐		Chronic Diarrhea
☐		Chronic Constipation
		CARIOVASCULAR
☐		Heart Disease
☐		Elevated Cholesterol
☐		Other
		METABOLIC/ENDOCRINE
☐		Type 1 Diabetes
☐		Type 2 Diabetes
☐		Metabolic Syndrome
☐		Hypothyroidism (low thyroid)
☐		Hyperthyroidism (overactive thyroid)
☐		Weight Gain
☐		Weight Loss
☐		Bulimia
☐		Anorexia
☐		Eating Disorder (Non-specific)
☐		Other
		CANCER
☐		

		NEUROLOGIC/MOOD
☐		Depression
☐		Anxiety
☐		Bipolar Disorder
☐		Schizophrenia
☐		Migraines
☐		Seizures

	Date	GENTIAL AND URINARY SYSTEMS
☐		Urinary Tract Infections
☐		Yeast Infections
		MUSCULOSKELETAL/PAIN
☐		Arthritis
☐		Chronic Pain
☐		Other
		INFLAMMATORY/AUTOIMMUNE
☐		Autoimmune Disease
☐		Poor Immune Function
☐		Food Allergies
☐		Environmental Allergies
☐		Multiple Chemical Sensitivities
☐		Latex Allergy
☐		Repeat or Recurrent Strep Throat
☐		Other
		RESPIRATORY DISEASES
☐		Frequent Ear Infections
☐		Frequent Upper Respiratory Infections
☐		Asthma
☐		Chronic Sinusitis
☐		Bronchitis
☐		Sleep Apnea
☐		Other
		SKIN DISEASES
☐		Eczema
☐		Psoriasis
☐		Acne
☐		Other
		NEUROLOGIC/MOOD
☐		Sensory Integrative Disorder
☐		Autism
☐		Mild Cognitive Impairment
☐		Headaches
☐		ADD/ADHD
☐		Other Neurological Problems

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FAMILY HISTORY

List all psychological and medical conditions that run in the patient's family:

Family Member	Current Conditions	Past Conditions
Mother		
Father		
Siblings		
Other		

Who does the patient live with? ____

Who are the main people who care for your child and what is their occupation? ____

____

TRAVEL HISTORY

Has the patient traveled to foreign countries? □ Yes □ No **Where?** ____________

____

Any wilderness camping? □ Yes □ No **Where?** ______________________________

____

Ever had: □ Gastroenteritis □ Diarrhea **Describe:** ___________________________

____

DENTAL HISTORY

Fillings?: □ Yes □ No **What kind?** ______________________________________

Other Dental Problems: □ Yes □ No **If so, please describe:** __________________

____

Regular Dental Visits?: □ Yes □ No

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MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (mo/yr)	Reason for Use

PREVIOUS MEDICATIONS *(Last 10 Years)*

Medication	Dose	Frequency	Start Date (mo/yr)	Reason for Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement and Brand	Dose	Frequency	Start Date (mo/yr)	Reason for Use

Have medications or supplements ever caused any unusual side effects or problems: □ Yes □ No **If so, please describe:** ______________________________

____

Has the patient had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? □ Yes □ No **If so please describe:** ______________________

____

Has the patient had prolonged or regular use of Tylenol? □ Yes □ No

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Has the patient had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.), Motrin, Aspirin? □ Yes □ No **If so please describe:** ____

Frequent antibiotics > 3 time/year? □ Yes □ No
Long term antibiotics? □ Yes □ No
Use of steroids (prednisone, nasal allergy inhalers) in the past? □ **Yes** □ **No**

GYNECOLOGIC HISTORY *(For Older Females Only)*

Age at first Period: _________ Menses Frequency: ________ Length: ____________________
Pain: □ Yes □ No Has your period ever skipped?: ______ For how long: _____________
Last Menstrual Period: ____________ Use contraception? □ Yes □ No If yes, please describe: ____
____

VISION AND HEARING

Vision	□ Normal	□ Abnl	□ Not Sure
Hearing	□ Normal	□ Abnl	□ Not Sure

IMMUNIZATIONS

Is your child up to date with immunizations?	□ *Yes* □ *No*
If not, what is your child not immunized for: ____	

EARLY CHILDHOOD ILLNESSES

Number of earaches in the past two years: ______________
Number of other infections in the first two years: ______________
Number of time your child had antibiotics in the first two years of life: ______________
First antibiotic at __________ months.
First illness at ______________ months.

PATIENT BIRTH AND DEVELOPMENTAL HISTORY

Mother's Past Pregnancies

Number of Pregnancies: ________________ **Number of Live Births:** ________________
Number of Miscarriages: _______________

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Mother's Pregnancy – *Check box if yes and provide description if applicable*

☐	Infertility drugs used – Specify:	☐	Have c-section because of
☐	Drink alcohol	☐	Have Rhogam, if so how may shots:
☐	Smoke tobacco		How many Rhogam shots when pregnant:
☐	Take prenatal vitamins	☐	Take antibiotics during Labor
☐	Take antibiotics during pregnancy	☐	Gestational Diabetes
☐	Take other drugs Specify:	☐	High blood pressure (pre-eclampsia)
☐	Excessive vomiting, nausea (more than 3 weeks)	☐	High blood pressure/toxemia
☐	Have a viral infection	☐	Have chemical exposure
☐	Have a yeast infection	☐	Father have chemical exposure
☐	Have amalgam fillings put in teeth	☐	Move to a newly built house
☐	Have amalgam filling removed from teeth	☐	House painted indoors
☐	Have bleeding? If so which months?	☐	House exterminated for insects
☐	Have birth problems		

PREGNANCY

Total weight gain during pregnancy: __________ **lbs.**
Total weight loss during pregnancy: __________ **lbs.**
Please describe diet during pregnancy: ____

____

____

Please describe labor: ____

____

____

PERINATAL

Pregnancy duration: *(Please indicate at what week your baby was born)*
☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30 ☐ 31 ☐ 32 ☐ 33 ☐ 34
☐ 35 ☐ 36 ☐ 37 ☐ 38 ☐ 39 ☐ 40 ☐ 41 ☐ 42 ☐ 43 ☐ 44
Very active before birth? ☐ Yes ☐ No
Hospital/Birthing Center? ☐ Yes ☐ No
Needed Newborn Special Care? ☐ Yes ☐ No
Appeared Healthy? ☐ Yes ☐ No
Easily consoled during first month? ☐ Yes ☐ No **If no, please describe:** ________

____

Antibiotics first month? ☐ Yes ☐ No **If so, please describe:** ____________________

____

Pediatric Mental Health Questionnaire

Experienced any complications during first month of life? ☐ Yes ☐ No If so, please describe: ____

____

BIRTH WEIGT AND APGAR

Weight at birth: __________ **lbs.** **Apgar score at 1 minute:** ________
Apgar score at 5 minutes: ______________

DEVELOPMENTAL HISTORY *Please indicate the approximate age in months for the following milestones:*

Sitting Up	months	☐ Never		Dry at night	months	☐ Never
Crawl	months	☐ Never		1st words	months	☐ Never
Pulled to stand	months	☐ Never		Spoke clearly	months	☐ Never
Potty trained	months	☐ Never		Lost language	months	☐ Never
Walked alone	months	☐ Never		Lost eye contact	months	☐ Never

Any developmental problems? ☐ Yes ☐ No **If so, please describe:** ____________

____
____
____

ANYTHING ELSE

Is there anything else that you would like me to know? ________________________

____
____
____
____