

Initial Clinical Questionnaire

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

Child's Name: _____ AGE: _____ Gender: [] M, [] F

Your Name & Relationship: _____ Today's Date: _____

Primary Care Physician (child's): _____

Therapist (list any from the past year): _____ [] current

How did you get my name? _____

If a person gave you my name, are they: your child's [] primary care physician; [] therapist;
your: [] therapist; [] friend; [] family member; [] religious leader; [] other: _____

1. Are there concerns about suicide risk? [] no, [] yes: _____

2. Are there concerns about violence toward others (toward whom)? [] no, [] yes: _____

If you have concerns about the risk of dangerous behavior in the near future, then you should consider whether it is necessary to see someone who could see you sooner (I am most likely to first see you between three weeks and three months from the time of our upcoming phone call). Your child's therapist or your primary care physician can help you make the decision about whether to wait for an appointment with me or not. Of course, hospital emergency departments or crisis centers are sources of emergency help, and should be used if necessary.

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 forensic evaluations only by special arrangement.]

3. Does your child have a specific diagnosis (es) for this problem? [] no, [] yes: _____

4. Is there a question as to whether your child has a particular diagnosis? [] no, [] yes: _____

5. Is he/she missing school or work due to this problem? [] no, [] yes: _____

6. Are there known or suspected psychotic symptoms (e.g. hallucinations, delusions, or very bizarre behavior)? [] no, [] yes: _____

7. Are there concerns about Substance Abuse? [] no, [] yes: _____

8. Are there serious current or chronic general health or medical problems? [] no, [] yes: _____

9. Is there a known or suspected developmental delay, intellectual disability ("mental retardation"), or Autism Spectrum Disorder? [] no, [] yes: _____

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 list the daily dosage for each medication): _____

12. Has your child had prior intensive treatment? [] no, [] yes: _____
[] Inpatient; [] Residential; [] Day Hospital; [] Day Treatment; [] Other: _____