**Mental Health Association in Indian River County Walk-In Center Evaluation Form: Child/Teen**

Child's Name: _____ Date: _____
(First) (Middle Initial) (Last)

**How did you hear about us?** ☐ 211 ☐ Behavioral Health Center ☐ Childcare Resources ☐ Connections Center ☐ CORE/Probation ☐ Clerk of the Court ☐ DCF ☐ Doctor:_____ ☐ Family ☐ Friend ☐ Health Department ☐ Healthy Start ☐ Hospital/Emergency Room ☐ Mental Health Court ☐ Print Ad ☐ Radio ☐ Return Client ☐ School ☐ Self ☐ Victims Advocacy ☐ Vocational Rehabilitation ☐ Website ☐ Other:_____
**Before today's visit, did you speak with a member of our clinical team by phone?** ☐ Yes ☐ No

Child's SS#: _____ Child's DOB: _____ Child's Age: _____ Child's Gender: _____

Child's Address: _____
(Street) (Apt.) (City) (Zip code)

County: ☐ Indian River ☐ St. Lucie ☐ Martin ☐ Brevard ☐ Other:_____

Child lives with: ☐ Both Parents ☐ Father ☐ Mother ☐ Other: _____

Parents' status: ☐ Married ☐ Never married ☐ Divorced (custody paperwork is needed) ☐ Separated

Are both parents aware of treatment needs of child? ☐ Yes ☐ No Any custody/court order? ☐ Yes ☐ No

**Your Name:** _____
(First) (Middle Initial) (Last)

Relationship to Child: ☐ Father ☐ Mother ☐ Stepparent ☐ Legal Guardian (proof of guardianship required)

Address: ☐ Same as child's ☐ As follows:

_____ County: _____
(Street) (Apt.) (City) (Zip code)

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Preferred contact #: ☐ Home ☐ Mobile ☐ Work

Can we leave a message? ☐ Yes ☐ No Email: _____

**Other Parent or Guardian's Name:** _____
(First) (Middle Initial) (Last)

Relationship to Child: ☐ Father ☐ Mother ☐ Stepparent ☐ Legal Guardian (proof of guardianship required)

Address: ☐ Same as child's ☐ As follows:

_____ County: _____
(Street) (Apt.) (City) (Zip code)

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Child's Highest Grade completed: _____ Child's race/ethnicity: _____

Estimated Gross Annual Income of Child's Household: _____

Do your child have health insurance coverage? ☐ Yes ☐ No Name: _____

Is your child a US citizen? ☐ Yes ☐ No

Briefly describe need for service: _____

_____

Are you seeking care due to an accident (auto, home, work, slip/fall) or symptoms due to an accident? ☐ Yes ☐ No

What services for your child are you looking for? ☐ Community Resources ☐ Counseling ☐ Group Therapy ☐ Parenting support ☐ Psychiatric Evaluation ☐ Psycho-educational Testing ☐ Psychotropic Medication

Has your child or family ever received our services? ☐ Yes ☐ No Describe _____

Has your child ever been diagnosed? ☐ Yes ☐ No Diagnosis: _____

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Has your child ever been Baker Acted or Psychiatrically Hospitalized or in Inpatient Care? ☐ Yes ☐ No
Describe:_____

Has your child had outpatient treatment (individual/group therapy, counseling, psychiatry)? ☐ Yes ☐ No
Describe:_____

Do your child have a prescriber for mental health meds? ☐ Yes ☐ No Provider: _____

| Current Medication Taken by Child | Dosage & Times per Day | Why Taken? | Who prescribes? |
|---|---|---|---|
| | | | |
| | | | |

Your child's strengths: _____

What does your child like to do with free time? _____

What clubs or community groups is your child involved with? ☐ None _____

Please note your child's blood relatives who have experienced the following.

| | |
|---|---|
| Cancer | ☐ None. If yes, who? |
| Heart Attacks | ☐ None. If yes, who? |
| Heart Disease | ☐ None. If yes, who? |
| Osteoporosis | ☐ None. If yes, who? |
| Strokes | ☐ None. If yes, who? |
| Thyroid Disease | ☐ None. If yes, who? |
| Alcoholism/alcohol abuse | ☐ None. If yes, who? |
| Drug Abuse | ☐ None. If yes, who? |
| Anxiety | ☐ None. If yes, who? |
| Depression | ☐ None. If yes, who? |
| Manic Depression (Bipolar) | ☐ None. If yes, who? |
| Panic Attacks | ☐ None. If yes, who? |
| Postpartum depression | ☐ None. If yes, who? |
| Psychosis | ☐ None. If yes, who? |
| Suicide | ☐ None. If yes, who? |
| Trauma | ☐ None. If yes, who? |

Members of your child's household:

| Name of Family Member | Gender | Age | Relationship to your child |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Does your child or family have pending/current legal issues (charges, court, custody, DCF)? ☐ Yes ☐ No
Describe:_____

Your child's birth order in your family ☐ Only child ☐ Oldest ☐ Middle ☐ Youngest ☐ None of these

Your child's academic performance: ☐ Failing grades ☐ Passing grades ☐ Academic honors

☐ Learning difficulties ☐ Repeated grade(s) _____

School experiences: ☐ Suspended ☐ Expelled ☐ Popular ☐ Several close friends ☐ Few friends

☐ Staff conflict ☐ Good relationship with school staff ☐ In sports or other activities

Does your child currently have a primary care physician? ☐ Yes ☐ No

Primary care physician: _____ Phone #: _____

Last physical examination Date: _____ Where? _____

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Has your child had any major illnesses (or had in the past)? ☐ Yes ☐ No Describe: _____

_____

What major surgeries or operations has your child had? ☐ None _____

_____

Has your child had any major injuries, especially head injuries? ☐ None _____

_____

Does your child have any known allergies? ☐ Yes ☐ No

To what? _____ What reaction? _____

To what? _____ What reaction? _____

Current Medications (Please include over the counter, vitamins, and/or other supplements) ☐ None

| Medication Name | Dosage, Times per Day | Why taken? | Who prescribes? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please check any of the following that are true for your child:

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Blurred vision | ☐ | Irregular or rapid heartbeat | ☐ | Nightmares/Bad Dreams |
| ☐ | Change in appetite | ☐ | Joint aches and pains | ☐ | Ringing in ears |
| ☐ | Change in weight by 5 lbs. or more in the last month | ☐ | Lack of energy | ☐ | Seizures |
| | | ☐ | Muscle aches and pains | ☐ | Shortness of breath |
| ☐ | Chronic cough | ☐ | Pain in your legs when walking | ☐ | Sleep disturbance |
| ☐ | Chronic sore throats | ☐ | Poor memory | ☐ | Hearing problems (please see staff for care plan) |
| ☐ | Dizziness | ☐ | Irregular or rapid heartbeat | | |
| ☐ | Fatigue | ☐ | Joint aches and pains | ☐ | Vision problems (need glasses, contacts) |
| ☐ | Feeling of fullness or bloating | ☐ | Muscle aches and pains | | |
| ☐ | Headaches | ☐ | Lack of energy | ☐ | Psychomotor problems (such as balance, movement) |
| ☐ | Inability to control bowel/bladder | ☐ | Muscle aches and pains | | |

Has your child ever threatened/attempted suicide ☐ Yes ☐ No (If yes, # of attempts____ # of threats ____)

Describe:_____

Does your child have access to any weapons? ☐ Yes ☐ No Describe: _____

(Our office is a weapon free environment. No weapons of any kind can be brought on site.)

Does your child share/report/display current harm to self? ☐ Yes ☐ No Describe: _____

_____

Does your child share/report/display current harm to anyone else? ☐ Yes ☐ No Describe: _____

_____

Does you have any concerns about alcohol or drug use by your child? ☐ N/A ☐ Yes ☐ No

Describe: _____

Has your child had a recent experience which was traumatic? ☐ Yes ☐ No

Describe: _____

Are you and your child safe in your current environment? ☐ Yes ☐ No Describe concerns: _____

_____

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Child's Name: _____ Date: _____
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Child's Height: _____ Child's Weight: _____

Child's current eating habits (Check all that apply): ☐ Healthy food choices ☐ Poor food choices

☐ 3 meals a day ☐ 2 meals a day ☐ Skipping meals ☐ Decreased appetite ☐ Overeating ☐ Purging

Child's current sleeping habits (Check all that apply): ☐ Restful ☐ 8 hrs. or more ☐ 8 hrs. ☐ 6-8 hrs.

☐ 4-6 hrs. ☐ Can't sleep ☐ Trouble falling asleep ☐ Toss and turn ☐ Nightmares ☐ Oversleeping

Your Child's Appetite ☐ high ☐ normal ☐ fair ☐ low

Your Child's Sleep ☐ high ☐ normal ☐ fair ☐ low

Your Child's Task completion ☐ high ☐ normal ☐ fair ☐ low

Cultural/Ethnic Influences: _____

Faith and Spirituality: _____

Are any of the following true for your child? ☐ death(s) of loved ones ☐ injuring self on purpose

☐ being aggressive ☐ being cruel to animals ☐ setting fires ☐ feeling rage frequently

☐ hearing or seeing things others cannot

Is there anything else you would like us to know about your child's (or family's) needs? ☐ N/A

_____

_____

_____

What has helped with the concerns you described (or what has helped in the past)?

_____

_____

_____

| Signature | | Date | |
|---|---|---|---|

**Mental Health Association in Indian River County Walk-In Center Evaluation Form: Child/Teen**

Child's Name: _____ Date: _____
(First) (Middle Initial) (Last)

**Pediatric Symptoms Checklist: For ages 4-16**

☐ Did not complete as my child is not between the ages of 4 to 16

Person Completing This Form _____

Instructions: Please mark under the heading that best fits your child.

| # | Behavior | NEVER | SOMETIMES | OFTEN |
|---|---|---|---|---|
| 1 | Complains of aches and pains | | | |
| 2 | Spends more time alone | | | |
| 3 | Tires easily, little energy | | | |
| 4 | Fidgety, unable to sit still | | | |
| 5 | Has trouble with a teacher | | | |
| 6 | Less interested in school | | | |
| 7 | Acts as if driven by a motor | | | |
| 8 | Daydreams too much | | | |
| 9 | Distracted easily | | | |
| 10 | Is afraid of new situations | | | |
| 11 | Feels sad, unhappy | | | |
| 12 | Is irritable, angry | | | |
| 13 | Feels hopeless | | | |
| 14 | Has trouble concentrating | | | |
| 15 | Less interest in friends | | | |
| 16 | Fights with other children | | | |
| 17 | Absent from school | | | |
| 18 | School grades dropping | | | |
| 19 | Is down on himself or herself | | | |
| 20 | Visits doctor or with doctor finding nothing wrong | | | |
| 21 | Has trouble with sleeping, rises very early | | | |
| 22 | Worries a lot | | | |
| 23 | Wants to be with you more than before | | | |
| 24 | Feels he or she is bad | | | |
| 25 | Takes unnecessary risks | | | |
| 26 | Gets hurt frequently | | | |
| 27 | Seems to be having less fun | | | |
| 28 | Acts younger than children his or her own age | | | |
| 29 | Does not listen to rules | | | |
| 30 | Does not show feelings | | | |
| 31 | Does not understand other people's feelings | | | |
| 32 | Teases others | | | |
| 33 | Blames others for his or her troubles | | | |
| 34 | Takes things that do not belong to him or her | | | |
| 35 | Refuses to share | | | |

**********

| ***For office coding TOTAL SCORE=*** | | | |
|---|---|---|---|