Bluebonnet Trails Community Services

Mental Health Intake Questionnaire – Child/Adolescent Version

Name of Youth: _____ Today's Date: _____

Name of Person Completing this Form:_____Relationship to Youth:_____

What challenges or problems have prompted you to seek services?

_____

What are your goals and/or expectations for care at Bluebonnet Trails Community Services?

_____

Please review the following and check any symptoms the youth is experiencing:

☐ Depressed mood	☐ Racing Thoughts	☐ Lack of enjoyment in usual activities
☐ Increased distractibility	☐ Trying to do too much	☐ Unintended changes in weight
☐ Agitated mood	☐ Sluggishness	☐ Sleeping too much or not enough
☐ Lack of energy/Fatigue	☐ Feeling guilty or worthless	☐ Seeing or hearing things that others do not see or hear
☐ Excessive worrying	☐ Inability to concentrate	☐ Intense fear of social situations
☐ Anger outbursts	☐ Inability to relax	☐ Attempts to hurt, harm, or mutilate self
☐ Panic attacks	☐ Too anxious to leave home	☐ Repetitive or obsessive thoughts
☐ Unreasonable fears	☐ Always on guard	☐ Repetitive actions
☐ Inflated self-esteem	☐ Lack of need for sleep	☐ Excessive or pressured speech

☐ Impulsivity ☐ Thoughts of death or suicide ☐ Violent thoughts or behaviors

☐ Inability to stay sober ☐ Recent drug / alcohol use ☐ Trauma

☐ Does not respect authority ☐ Aggression/bullying ☐ Stealing

☐ Fire-setting ☐ Abuse of animals ☐ Damaging property

☐ Deceitfulness ☐ Blaming others ☐ Truancy/Running Away

☐ Other:

Past behavioral health treatment:

Inpatient psychiatric hospitalization? ☐ Yes, # of admissions:_____ ☐ No

Detoxification? ☐ Yes, # of admissions:_____ ☐ No

Rehabilitative treatment? ☐ Yes, # of admissions:_____ ☐ No

Intensive outpatient treatment? ☐ Yes, # of admissions:_____ ☐ No

If yes, when and where? _____

Current or past outpatient psychiatric or substance use treatment:

Psychiatrist or Nurse Practitioner office visits? ☐ Yes ☐ No

Therapy with a Psychologist or Counselor? ☐ Yes ☐ No

If yes, when and where? _____

Prior Diagnoses: _____

Bluebonnet Trails Community Services

Health/Education Screening

Name of Primary Care Provider: _____

Date of last visit with primary care provider? _____

Is the young person allergic or sensitive to any medications? □ Yes □ No

If yes, please list:_____

Describe any recent changes in appetite: _____

Describe any challenges with sleep: _____

Height:_____ Weight: _____ Current Pulse Rate: _____ Temperature: _____

Blood Pressure (if able to provide):_____

Current Grade Level:_____

Is the young person receiving special education services or accommodations? □ Yes □ No

If yes, please describe: _____

Please list all ***current*** psychiatric and medical medications:

Name	Dose	Frequency	Provider's Name	Date started

Please list all psychiatric medications ***previously*** taken:

Name	Benefits	Side Effects	Reason discontinued

Health Insurance Information (if applicable):

Name of Health plan:_____ Name of Insured Person: _____

Policy #:_____ Effective Date: _____

Additional information we need to know about you or the young person's situation at this time:

_____