HURLEY MENTAL HEALTH ASSOCIATES
CHILDREN'S QUESTIONNAIRE

*Date*_____

*Child's Name*_____*Birthdate*_____*Age*____

*Person Completing Form*_____*Relationship*_____

PREGNANCY AND DELIVERY

*Age of mother at time of delivery*_____
*Number of previous pregnancies (including miscarriages and stillborns)*_____
*Describe your pregnancy with this child*_____
_____
Was this pregnancy planned? Yes No
Were any of the following experienced during pregnancy?

____*Spotting*	____*Anemia*	____*Nervousness*
____*Excessive Swelling*	____*Vomiting*	____*X-Ray*
____*Kidney Infection*	____*High Blood Pressure*	____*Other Special Tests*
____*Urinary Infection*	____*Depression*	____*Ultra Sound*
____*Excessive Weight Gain*	____*Excessive Tiredness*	____*Other*

*Name of Physician*_____*Number of Pre-natal Visits*_____

How many pounds were gained during pregnancy? _____

What medication did you take during pregnancy? _____

How long was labor? _____

*Was labor induced? Yes No Method*_____

Was this a full term pregnancy? Yes No
*If not, how early*_____*or how late*_____

Please check if any of the following were experienced during delivery:

____*Breech Birth*	____*Anesthetic*	____*Jaundice (yellow color)*
____*Instruments*	____*RH Incompatibility*	____*Incubation*
____*Cesarean*	____*Birth Injuries*	____*Convulsions*
____*Anoxia (Blue Baby)*	____*Malformations*	____*Other Difficulties*

Did infant require: Oxygen Blood Transfusion X-ray

Did mother require: Oxygen Blood Transfusion X-ray

*Birth weight of child:*_____*lbs.*_____*ozs.*

Did baby go home from hospital when mother did? Yes No
*If not how long was baby hospitalized?*_____*For what reason?* _____
Describe your labor and delivery with this child:
_____
_____
_____

EARLY INFANCY

Did baby eat well? Yes No
Did baby gain weight normally? Yes No
Did baby have colic? Yes No
Was baby breast-fed? Yes No
Was baby bottle-fed? Yes No
Did baby have sleeping problems? Yes No
Were there any feeding difficulties? Yes No
Comments:

_____
_____

LATER INFANCY AND CHILDHOOD

At what age in years and months did your child?

	Months	*Years*
Crawl	_____	_____
Sit	_____	_____
Stand	_____	_____
Speak Words	_____	_____
Stay dry during the day	_____	_____
Stay dry during the night	_____	_____
Trained for bowel movements	_____	_____

How did child react to toilet training? _____
_____

Was your child slower or faster in developing that you expected? _____

ADDITIONAL HEALTH HISTORY

List below illnesses, injuries and operations your child has had:

	Age	*Duration*	*Hospitalized*		*Physician*
_____	____	_____	*Yes*	*No*	_____
_____	____	_____	*Yes*	*No*	_____
_____	____	_____	*Yes*	*No*	_____

Were any of the illnesses, injuries or operations accompanied by a high fever? Yes No
How high? _____

*Child's Name*_____ *DOB*_____

Check if your child has been troubled with any of the following:

____*Asthma*	____*Eye Problems*	____*Sore Throat*	____*Nose bleeds*
____*Hay Fever*	____*Severe Colds*	____*Ear Aches*	____*Anemia*
____*Eczema*	____*Bronchitis*	____*Headaches*	____*Stomach Aches*
____*Allergies*	____*Measles*	____*Rheumatic Fever*	____*Other*
____*Convulsions*	____*Seizures*	____*Blackouts*	

Has hearing been tested? Yes No Where? _____

Results? _____

Has vision been tested? Yes No Where? _____
Does child wear/need glasses? Yes No How long? _____

Does child have speech problems? Yes No
Explain: _____

Are there any other significant FAMILY illnesses? Yes No
If so who? _____ *Illness?* _____

SCHOOL HISTORY

Did your child attend preschool? Yes No Where _____
Did your child have any problems beginning school? Yes No
Explain: _____
Has your child ever failed a grade or been held back? Yes No What grade(s) _____
Does your child experience problems in the following areas?

____*Reading*	____*Paying Attention*	____*Math*
____*Obeying Rules*	____*Spelling*	____*Teachers*
____*Fighting*	____*Attendance*	____*Making Friends*

Has your child been in accelerated classes? Yes No What grades _____
Is your child in or being considered for special education? Yes No
Has your child been tested by the school psychologist? Yes No When _____
Results? _____
Has your child received school social work services? Yes No
How does your child feel about school?

_____

_____

OLDER CHILDREN

Have you noticed any body changes in him/her? Yes No When? _____
Has she started menstruating? Yes No When? _____
Have there been any problems with these changes? Yes No
Explain: _____
Is your child dating? Yes No
Does he/she smoke? Yes No Drink? Yes No Use Drugs? Yes No
Is he/she sexually active? Yes No

Child's Name _____ *DOB* _____

HOUSEHOLD AND FAMILY MEMBERS

(Please include those immediate family members not living in the home)

Name	*DOB*	*Sex*	*Relationship*	*Education*	*City*	*Occupation*

*Other births:*_____

Deaths of significant family members:

_____

_____

_____

Dates of other marriage(s), separation(s), divorce(s):

_____

_____

_____

Has he/she ever witnessed or experienced emotional, physical or sexual abuse? Yes No
*If yes, please explain:*_____

_____

_____

What kind of help do you hope to receive? _____

_____

_____

_____

_____

*Child's Name*_____ *DOB*_____

HURLEY MENTAL HEALTH ASSOCIATES
HEALTH QUESTIONAIRE

*PATIENT NAME (Print Only)*_____

Height: _____ *Weight:* _____

1. *Do you have any medical symptoms at the time of this interview or persistent chronic or acute symptoms, which have lasted for more than a week such as pain, physical complaints, etc?*
   *Yes_____ No_____ Specify*_____
2. *Please indicate any physical disabilities, limitations, or ailments for which you have been treated:*
   _____
   _____
3. *Do you have a history of intravenous drug use, unconsciousness, hepatitis, or DT'S?*
   *Yes _____No _____ Specify*_____
4. *Do you have communicable disease (including any sexually transmitted diseases)?*
   *Yes_____ No_____ Specify*_____
5. *When were you last treated by a physician?* _____
   For what? _____
6. *When and where was your last physical?* _____
7. *Have you ever had surgery Yes ____ No _____ For what?* _____
   _____
   _____
8. *Do you smoke cigarettes? Yes_____ No_____*
   If yes, how many per day or per week? _____
9. *Do you drink alcoholic beverages? Yes_____ No_____*
   If yes, how much and how often? _____
10. *Do you drink caffeinated beverages (coffee, tea, colas, Mt. Dew, etc..)?*
    Yes_____ No_____ If yes, how much per day? _____
10. *Have you ever been in treatment at a detox or residential substance abuse or psychiatric program?*
    *Yes_____ No_____ Date Last Attended:*_____

*COMMENTS*_____
_____

Have you ever been in counseling or therapy before? Yes_____ No_____,
If so please explain:

_____
_____
_____
_____

(over)

Briefly describe your reason for seeking help _____

_____

_____

Please give any additional information that may be of any help to us:

_____

_____

_____

_____

Please circle any of the following problems, which pertain to you:

Nervousness	*Depression*	*Fears*
Shyness	*Sexual Problem*	*Suicidal Thoughts*
Separation	*Divorce*	*Finances*
Drug Abuse	*Alcohol Use*	*Unhappiness*
Anger	*Self Control*	*Friends*
Sleep	*Stress*	*Work*
Relaxation	*Headaches*	*Tiredness*
Legal Matters	*Memory*	*Ambition*
Energy	*Insomnia*	*Loneliness*
Decision Making	*Concentration*	*Thoughts*
Education	*Career Choices*	*Health Problems*
Temper	*Nightmares*	*Marriage*
Children	*Appetite*	*Stomach Trouble*
Bowel Trouble	*Pain*	

*CLIENT SIGNATURE*_____*DATE*_____

Revised 7-16-12

HURLEY MENTAL HEALTH ASSOCIATES

MEDICATION LIST

Patient Name: _____

Date of Birth: _____

ALLERGIES: _____ **Date/Initials**_____ _____
Date/Initials_____

_____ **Date/Initials**_____ _____ **Date/Initials**_____

_____ **Date/Initials**_____ _____ **Date/Initials**_____

Drug Name **(include dose, route, frequency)**	**Date Reviewed/** **Initials**	**Date Reviewed/** **Initials**	**Date Reviewed/** **Initials**	**Date Reviewed/** **Initials**	**Date Reviewed/** **Initials**

KEY:

Initials:_____ Name:_____ Clinic:_____ Initials:_____ Name:_____ Clinic:_____

Initials:_____ Name:_____ Clinic:_____ Initials:_____ Name:_____ Clinic:_____

Initials:_____ Name:_____ Clinic:_____ Initials:_____ Name:_____ Clinic:_____

Revised 7-16-14

Patient Name:_____ Date:_____

Center for Epidemiologic Studies Depression Scale (CES-D)

Instructions: Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way **during the past week**.

	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.				
2. I did not feel like eating; my appetite was poor.				
3. I felt that I could not shake off the blues even with help from my family or friends.				
4. I felt I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I enjoyed life.				
17. I had crying spells.				
18. I felt sad.				
19. I felt that people disliked me.				
20. I could not get "going."				