

C.20 Mental Health Interview Tool/Referral Form (Ages 10–12 Years)

Mental Health Parent Questionnaire

Child's Name: _____

Birth Date: _____

Ages 10 to 12 Years

Today's Date: _____

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

F e e l i n g s	Does your child (do you) show feelings that concern you or seem strange for their (your) age? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Is restless <input type="checkbox"/> Is sad or cries easily <input type="checkbox"/> Is guilty <input type="checkbox"/> Is irritable or angers easily	<input type="checkbox"/> Is sullen <input type="checkbox"/> Is fearful <input type="checkbox"/> Is bored

B e h a v i o r	Does your child (do you) often do things that seem strange for their (your) age? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Has problems in school <input type="checkbox"/> Threatens or harms other children or animals <input type="checkbox"/> Lacks interest in things s/he used to enjoy <input type="checkbox"/> Is involved in sexual activity <input type="checkbox"/> Destroys possessions or other property <input type="checkbox"/> Steals	<input type="checkbox"/> Refuses to talk <input type="checkbox"/> Sets fires <input type="checkbox"/> Is overactive <input type="checkbox"/> Hurts himself or herself <input type="checkbox"/> Has been in trouble with the police

S o c i a l i n t e r a c t i o n	Do you have any concerns about how your child (you) get(s) along with family members? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	With other adults? <input type="checkbox"/> Yes <input type="checkbox"/> No With other children? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Prefers to be alone <input type="checkbox"/> Has a hard time making and keeping friends <input type="checkbox"/> Is defiant, a disciplinary problem	<input type="checkbox"/> Picks on others a lot or often gets into fights (hitting, etc.) <input type="checkbox"/> Argues too much <input type="checkbox"/> Will not go to school

T h i n k i n g	Are any of these a problem for your child (you)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Is frequently confused (does not understand what is going on) <input type="checkbox"/> Daydreams a lot <input type="checkbox"/> Is distracted, doesn't pay attention <input type="checkbox"/> Has very strange thoughts <input type="checkbox"/> Schoolwork is slipping (grades going down)	<input type="checkbox"/> Does not trust others <input type="checkbox"/> Sees or hears things that are not there <input type="checkbox"/> Blames others for his/her misdeeds or thoughts <input type="checkbox"/> Talks about death or suicide a lot <input type="checkbox"/> Often cannot remember things