

C.22 Mental Health Interview Tool/Referral Form (Ages 13–20 Years)

Mental Health Interview Tool/Referral Form

Child's Name: _____

Birth Date: _____

Date: _____

Ages 13 to 20

You may begin with a joint interview or begin with separate interviews with the parent/caregiver and adolescent. It is preferable to interview the adolescent first. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.

Feelings:

Do you (does your teen) have feelings that concern you or seem out of the ordinary for (their) age?

- Restless
- Sad or cries easily
- Guilty
- Irritable or angers easily
- Sullen
- Fearful or anxious
- Bored

Behavior:

Do you (does your child) behave in ways that seems out of the ordinary for your (their) age?

- Problems at school or work
- * Threatens or harms other children or animals
- Lacks interest in things s/he used to enjoy
- Engages in sexual play with others, toys, animals
- * Destroys possessions or other property
- Steals
- Refuses to talk
- * Sets fires
- Overactive
- * Has been in trouble with the police
- * Self-destructive

Social Interaction:

Do you have concerns about how (you) your child gets along with family members, other adults, or peers?

- Prefers to be alone
- Difficulty making and keeping friends
- Defiant, a discipline problem
- Aggressive
- Argues excessively
- Refuses to go to school

Thinking:

Have you noticed any of the following to be a problem for you (your child)?

- * Frequently confused
- Daydreams excessively
- Distracted, doesn't pay attention
- Mistrustful
- * Sees or hears things that are not there
- Blames others for his/her misdeeds or thoughts
- * Talks about death or suicide
- * Frequent memory loss
- * Bizarre thoughts
- Schoolwork is slipping (grades going down)

Physical Problems:

Do you have any concerns about the following physical signs? Has this been evaluated?

- Lacks energy
- Uses laxatives
- Vomits frequently
- Food refusal, secretive eating
- Frequent stomachaches
- Headaches
- Excessive weight loss or gain
- Sleep problems, nightmares, sleep-walking, early waking, frequent night waking

Other:

Are you (is this child) accident-prone?

Are there any situations that are causing your family particular stress?

Have you (has this child) or your (his/her) parents been subject to neglect, physical, sexual or emotional abuse? If yes, what type, when, treatment, etc.

- * Are you (is this child) at risk for out-of-home placement because of behavior problems?
- Have you (has this child) been treated for mental health problems or substance abuse?

Substance Abuse Questions:

(May want to use screens such as the TACE, CAGE, MAST to obtain information concerning substance abuse.)

- Has been identified as a problem

Comments:

Signature/Title: _____