MENTAL HEALTH QUESTIONNAIRE - Solo

MENTAL HEALTH QUESTIONNAIRE

1. **Client information:**

Client's First Name: _____ Client's Last Name: _____ Date of Birth: _____

Your Preferred Service Location:

- ☐ 209 Cherry St, Milford, CT
- ☐ 29 Federal Rd. Danbury, CT

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

2. **How would you rate your child's current physical health? (please check)**

- ○ Poor
- ○ Unsatisfactory
- ○ Satisfactory
- ○ Good
- ○ Very good

Please list any specific health problems your child is currently experiencing:

_____

3. **How would you rate your child's current sleeping habits? (Please check)**

- ○ Poor
- ○ Unsatisfactory
- ○ Satisfactory
- ○ Good
- ○ Very good

Please list any specific sleep problems you are currently experiencing:

_____

4. **How many times per week does your child generally socialize?**

_____

5. **What types of socializing do they participate in?**

_____

6. **Please list any difficulties your child experiences with appetite or eating patterns.**

_____

_____

_____

_____

7. Is your child currently experiencing overwhelming sadness, grief or depression?

- Yes
- No

If yes, for approximately how long?

_____

8. Is your child currently experiencing anxiety, panic attacks or have any phobias?

- Yes
- No

Is your child currently experiencing anxiety, panic attacks or have any phobias?

_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you/ your child in the space provided (father, grandmother, uncle, etc.).

9. Please Check if Applicable & List Family Member

	Yes	Family member
Alcohol/Substance Abuse		
Anxiety		
Depression		
Domestic Violence		
Eating Disorders		
Obesity		
Obsessive Compulsive Behavior		
Schizophrenia		
Suicide Attempts		

10. What do you consider to be some of your child's strengths?

_____

_____

_____

_____

11. What do you consider to be some of your child's weaknesses?

_____

_____

_____

_____