# Child and Youth Mental Health Clinician Screening Form

## History obtained by: ____________________________ Date/Time: ____________________________

1. **ID/Referral**: Source and reason for referral, who patient lives with, source of information

2. **Chief Complaint/HPI**: time of onset, duration, predisposers, precipitators, perpetuators, severity

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### Screen for Mood Symptoms:
- [ ] depressed/irritable mood
- [ ] reactivity
- [ ] social isolation/withdrawal
- [ ] less interest/pleasure, anhedonia
- [ ] changes in appetite or weight
- [ ] sleep disturbance
- [ ] agitation / retardation
- [ ] loss of energy / fatigue
- [ ] worthlessness, inappropriate guilt
- [ ] poor concentration, indecisiveness
- [ ] low self-esteem
- [ ] feelings of hopelessness
- [ ] mood elevation
- [ ] grandiosity
- [ ] pressured speech
- [ ] other mania

### Screen for Psychotic Symptoms:
- [ ] circumstantiality
- [ ] loosening of associations
- [ ] delusions
- [ ] auditory hallucinations
- [ ] visual hallucinations
- [ ] tactile hallucinations
- [ ] communicating telepathically
- [ ] thought broadcasting
- [ ] thought insertion
- [ ] thought withdrawal
- [ ] catatonic behaviour
- [ ] flat/inappropriate/incongruent affect

### Screen for Anxiety Symptoms:
- [ ] worries – generalized anxiety
- [ ] phobias-age inappropriate
- [ ] panic
- [ ] obsessions - compulsions
- [ ] dissociation
- [ ] flashbacks
- [ ] avoidance

### Screen for Substance Use:
- [ ] Alcohol
  - Frequency:
  - Amount:
- [ ] Substance use
  - Frequency:
  - Amount:
- [ ] Cigarettes
  - Frequency:
  - Amount:
3. **Risk of Suicide**
   Thoughts about death, dying or killing self/how long:
   Plan for doing this:
   - Means available (e.g. pills, guns, knives, poison, etc.):
   - Have you rehearsed or practiced:
   - Previous attempts, method, severity:

4. **Risk of Harm to Others**
   Thoughts about hurting or killing others/who/how long:
   Plan for doing this:
   - Means available (e.g. guns, knives, poison, etc.):

5. **Past Psychiatric History:** diagnosis, medications, involvement with CAS/CCAS/JFCS/children’s mental health agencies, counsellors (including guidance counsellor)

6. **Personal History:** social, academic & behavioural functioning, sexual or physical abuse, substance abuse, aggression and violence, body image & eating problems, sexual preference/orientation

7. **Family History:** relationships, psychiatric history (include medications), suicides in family including extended family
8. **Mental Status:** appearance and behaviour, speech and language, estimate level of intellectual functioning, affect and mood, frustration tolerance and impulsivity, task orientation, insight and locus of control

9. **Current Supports:** what supports are available and do they currently have involvement with a community mental health agency

10. **Parent/Custodian** willing to ensure supervision and safety of child?
    (health teaching re: safety measures provided):
    
    [ ] Yes  [ ] No

**Management & Disposition**

______________________________ ______________________________

CY MHC Signature                        MD Signature

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Discussed with ________________________________

A copy of this form to be forwarded to:

1. The referred community MH agency  [ ] Sent
2. The patient's primary care provider  [ ] Sent