Child and Youth Mental Health Clinician Screening Form

Patient Identification

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

Screen for Mood Symptoms:	Screen for Psychotic Symptoms:	Screen for Anxiety Symptoms:	Screen for Substance Use:
☐ depressed/irritable mood	☐ circumstantiality	☐ worries – generalized anxiety	☐ **Alcohol**
☐ reactivity	☐ loosening of associations	☐ phobias-age inappropriate	Frequency:
☐ social isolation/withdrawal	☐ delusions	☐ panic	Amount:
☐ less interest/pleasure, anhedonia	☐ auditory hallucinations	☐ obsessions - compulsions	☐ **Substance use**
☐ changes in appetite or weight	☐ visual hallucinations	☐ dissociation	Frequency:
☐ sleep disturbance	☐ tactile hallucinations	☐ flashbacks	Amount:
☐ agitation / retardation	☐ communicating telepathically	☐ avoidance	☐ **Cigarettes**
☐ loss of energy / fatigue	☐ thought broadcasting		Frequency:
☐ worthlessness, inappropriate guilt	☐ thought insertion		Amount:
☐ poor concentration, indecisiveness	☐ thought withdrawal		
☐ low self-esteem	☐ catatonic behaviour		
☐ feelings of hopelessness	☐ flat/inappropriate /incongruent affect		
☐ mood elevation			
☐ grandiosity			
☐ pressured speech			
☐ other mania			

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**

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