INITIAL SCREENING QUESTIONNAIRE FOR CHILDREN/ADOLESCENTS
William T. Goldman, M.D.

NAME: _____ **TODAY'S DATE**: _____

AGE: _____ **GRADE:** _____ **PARENT/LEGAL GUARDIAN'S NAME:** _____

DATE SYMPTOMS BEGAN: _____ **DATE SYMPTOMS WORSENED**: _____

STRESSFULL EVENTS/SITUATIONS: _____

_____

SYMPTOM CHECKLIST

○ = Past Issue □ = Present Issue

- ○□Depressed or Sad Mood
- ○□Irritability/Short Tempered
- ○□Lack of Motivation/Drive
- ○□Poor Concentration
- ○□Can't Sleep Well
- ○□Appetite Changes □Weight Change?
- ○□Loss of Pleasure in Activities/Hobbies
- ○□Diminished Self-Esteem
- ○□Hopeless/Helpless
- ○□Decreased Energy/Always Tired
- ○□Excessive Guilt
- ○□Crying Spells/Easily Put to Tears
- ○□Frequent Headaches/Stomach Aches
- ○□Intense Fear of Being Fat

- ○□Spending Sprees/Wasting Money
- ○□Special Abilities/Increased Self Esteem
- ○□Decreased Need for Sleep
- ○□Too Many Great Ideas to Get Out at Once
- ○□Racing Thoughts/Can't Keep Up
- ○□Increased Energy/Hyperactive
- ○□Increased Sex Drive
- ○□Making Lots of Plans/Schemes/Ideas
- ○□Rapid Speech
- ○□Talking Nonstop/Can't Interrupt
- ○□Day-to-Day Mood Swings

- ○□Suspiciousness/Paranoia
- ○□Hallucinations (Seeing or Hearing Things)
- ○□Unusual Facial Expressions
- ○□Strange Posturing/Gestures
- ○□Disorganized Thoughts/Confusion
- ○□Bizarre Behaviors
- ○□Unusual or Unwanted Beliefs/Thoughts
- ○□Washes Hands Constantly

- ○□Anxiety About Everything
- ○□Fears for Parents' Safety
- ○□Fear of Going Crazy/Losing Control
- ○□Chills/Hot Flashes
- ○□Abdominal Distress/Nausea
- ○□Sleep walks
- ○□Dizziness
- ○□Numbness/Tingling
- ○□Jumpy/On Edge/Easily Startled
- ○□Constantly Alert/Vigilant
- ○□Nightmares/Reliving Traumas
- ○□Avoidance of Stressors/Situations
- ○□Heart Racing/Palpitations
- ○□Sweating/Trembling/Shaking
- ○□Odd, Rigid Habits
- ○□Shortness of Breath/Smothering
- ○□"Lump in Throat"/Can't Swallow
- ○□Attacks of Intense Anxiety/Fear/Panic
- ○□Unable to Leave Home/Go to School

- ○□Counts Things Constantly
- ○□Says Strange Things
- ○□Language/Speech Difficulties
- ○□Poor Judgment/Impulsivity
- ○□Unusual Sleep Pattern
- ○□Disorganized/Confused
- ○□Poor Memory

SUBSTANCE ABUSE

- ○□Amphetamines/Stimulants
- ○□Cocaine/Crack
- ○□Marijuana/Cannabis
- ○□Alcohol
- ○□Tranquilizers/Sleeping Pills
- ○□Opiates/Narcotic Pain Pills/Heroin
- ○□Treatment or Detox Program?

SUICIDAL THOUGHTS □**Yes** □**No**

- ○□Passing Thoughts/No Intent
- ○□Persistent Thoughts
- □Current Plans/Definite Intent
- □Recent Attempts
- □Past Attempts

- ○□Pulling Hair Out
- ○□Anger/Emotional Outbursts
- ○□Binge Eating/Stress Eating
- ○□Poor Frustration Tolerance
- ○□Stealing or Lying
- ○□Has Few Friends

- ○□Oppositional/Defiant Behaviors
- ○□Delinquency/Legal Troubles
- ○□Attention/Concentration Difficulties
- ○□Impulsivity/Can't Wait
- ○□Hyperactivity/Always Moving/Restless

- ○□Poor Self Care/Bathing/Dressing
- ○□Can't Perform at Work/Home/School
- ○□Aggressive/Assaultive to People/Objects
- ○□Isolative/Withdrawn from Others
- ○□Truancy from School
- ○□Running Away from Home
- ○□Self-Mutilation/Self-Harm
- ○□Sleeping All the Time
- ○□Staring Spells
- ○□Chronic Pain
- ○□Multiple Unexplained Bodily Complaints
- ○□Makes Self Vomit
- ○□Constant Agitation
- ○□Intense Fear of Rejection/Abandonment
- ○□Bowel /Bladder Control Problems
- ○□Poor Social Skills

III. MEDICATIONS

CURRENT: _____

PAST ONES TRIED: _____

IV. ALLERGIES TO MEDICATIONS: _____

V. PAST PSYCHIATRIC HISTORY □Counseling □Psychiatrist Visits □Hospitalization □Suicide Attempts

VI. CURRENT/PAST MEDICAL ISSUES: _____

VIII. FAMILY HISTORY: □Psychiatric/Emotional Illness □Medical Diseases □Suicide Attempts □Drug/Alcohol Problems

THANK YOU.