[Standard Header]

Claimant Name: [Clmt Full Name]

## PLEASE COMPLETE AND RETURN BY {current + 14 days}

## MENTAL STATUS QUESTIONNAIRE for MEDICAL SOURCE - CHILD

1. Date first seen:_____ Date last seen:_____ Frequency of visits:_____

2. Provide a brief psychiatric history (e.g., onset, symptoms, exacerbations, therapy, hospitalizations):

3. List prescribed psychiatric medications and indicate any adverse effects:

4. Describe the child's current mental status and indicate any significant recent changes:

   a. APPEARANCE –

   b. BEHAVIOR –

   c. ATTENTION AND CONCENTRATION –

   d. MOOD AND AFFECT –

   e. COMMUNICATIVE ABILITIES AND BEHAVIOR –

   f. THOUGHT PROCESS AND CONTENT –

   g. COGNITIVE FUNCTIONING –

   h. JUDGMENT AND INSIGHT –

   i. SUICIDAL OR HOMICIDAL IDEATION –

5. Provide the child's DSM-5 diagnosis(-es), if applicable:

6. If there is a substance use disorder, describe any significant periods of abstinence, including how long these periods lasted and any effects on the child's functioning:

7. Current prognosis of the child's psychiatric impairment(s) and any treatment recommendations:

8. Probable duration of the child's psychiatric impairment(s):

9. Specify any limitations in age-appropriate functioning that result from impairment(s) :

a. Acquiring and using information –

b. Interacting and relating with others –

c. Attending and completing tasks –

d. Caring for themselves –

**If you need more space, please attach additional page(s).**

_____

Signature, Degree/License Type, Print Name & Date

Phone number: _____ Best time to call: _____

If you are not independently licensed as a physician, psychologist, APRN, or physician assistant, but you co-treat the patient with a clinician having such license, please have that clinician cosign this report if possible.

_____

Co-Signature, Degree/License Type, Print Name & Date