**State of Delaware**

**Early and Periodic Screening, Diagnosis, Treatment (EPSDT)**

**Mental Health and Substance Abuse Screen**

Child Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency/Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Source of Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIRECTIONS:**

Please consider the problems that your child is having when filling out the form below. Please think about your child’s age and developmental level when answering the questions. If the problem applies to your child please check the most appropriate box. In some cases it will be appropriate to check both boxes. That is okay. If the problem has never happened please leave the box blank.

|  |  |  |
| --- | --- | --- |
| **CHILD’S HISTORY** |  **In last** **30 Days** | **Ever** |
| 1. Suicidal thoughts/threats
 |  |  |
| 1. Suicidal gestures
 |  |  |
| 1. Suicide attempts requiring hospitalization
 |  |  |
| 1. Injures self, e.g., cutting**,** head-banging , burning, picking skin
 |  |  |
| 1. Homicidal – Statements of killing others
 |  |  |
| 1. Physically violent – Physically hurting others
 |  |  |
| 1. Verbally threatening - Threatening to hurt others
 |  |  |
| 1. Frequent, intense, uncontrollable temper tantrums
 |  |  |
| 1. Hallucinations (sees or hears things that aren’t there)
 |  |  |
| 1. Delusions (has strong beliefs which have no basis in reality)
 |  |  |
| 1. Cruel to animals
 |  |  |
| 1. Willful destruction of property
 |  |  |
| 1. Fire setting
 |  |  |
| 1. Victim of physical Abuse confirmed/suspected
 |  |  |
| 1. Victim of Sexual Abuse confirmed/suspected
 |  |  |
| 1. Victim of Emotional Abuse confirmed/suspected
 |  |  |
| 1. Suspected or confirmed victim of caregiver neglect, e.g. failure to provide food, shelter or clothing.
 |  |  |
| 1. Inadequate or inappropriate parental supervision and/or discipline
 |  |  |
| 1. Exposure to Domestic Violence
 |  |  |
| 1. Wetting or Soiling (after potty training)
 |  |  |
| 1. Overly sensitive to environment (noise, touch) which causes distress
 |  |  |
| 1. Difficulty separating from parents, school refusal
 |  |  |
| 1. Recurrent intrusive thoughts or repetitive behaviors, such as hand washing, lock checking, organizing objects
 |  |  |
| 1. Persistent unrealistic worry over physical health
 |  |  |
| 1. Avoids people, places or things
 |  |  |
| 1. Always seems jumpy or afraid
 |  |  |
| 1. Gets upset when remembering bad thing that have happened to him/her.
 |  |  |
| 1. Many nightmares
 |  |  |
| 1. Child has experienced traumatic event, e.g. flood, hurricane; frightening medical procedure; being or seeing someone severely injured (accident or assault); seeing a dead body or someone killed.
 |  |  |
| 1. Psychosocial stressors, e.g., death, absence or loss of significant person in child’s life and/or multiple life changes, serious illness in family, economic problems
 |  |  |
| 1. Instability of residential arrangement, e.g., homelessness, multiple placements, frequent relocations
 |  |  |
| 1. Problems with same age peers
 |  |  |
| 1. Problems with family relationships or relationships with authority figures
 |  |  |
| 1. Inability to give or receive appropriate affection to primary caregivers
 |  |  |
| 1. Arrested, detained, or on probation
 |  |  |
| 1. Gambling
 |  |  |
| 1. Inappropriate sexual activity
 |  |  |
| 1. Running away
 |  |  |
| 1. Suspected or confirmed abuse of alcohol or other drugs/substances
 |  |  |
| 1. Confirmed or suspected developmental/Intellectual delay
 |  |  |
| 1. Problems in school/vocational activity (attendance, behavior, performance)
 |  |  |
| 1. Difficulty in concentration
 |  |  |
| 1. Excessive sadness, crying, withdrawal
 |  |  |
| 1. Easily angered or excessive anger.
 |  |  |
| 1. Excessive irritability
 |  |  |
| 1. Excessive fears or worries
 |  |  |
| 1. Irregular or problematic eating/appetite patterns
 |  |  |
| 1. Medical condition complicated by emotional disturbance or medical noncompliance
 |  |  |

|  |
| --- |
| **FAMILY HISTORY** |
| **PROBLEM** | **Mother**  | **Father** | **Guardian** | **Sibling** | **Grandparent** | **Other** |
| 1. History of Self Harm - i.e. Cutting, Burning
 |  |  |  |  |  |  |
| 1. Attempted Suicide
 |  |  |  |  |  |  |
| 1. Completed Suicide
 |  |  |  |  |  |  |
| 1. History of Mental Health Issues
 |  |  |  |  |  |  |
| 1. Current Mental Health Issues
 |  |  |  |  |  |  |
| 1. History of Substance Abuse
 |  |  |  |  |  |  |
| 1. Current Substance Abuse
 |  |  |  |  |  |  |
| 1. History of Incarceration
 |  |  |  |  |  |  |
| 1. Current Incarceration
 |  |  |  |  |  |  |
| 1. Domestic Violence
 |  |  |  |  |  |  |

***Submission of this form does not constitute a formal abuse report. Mandated reporters are legally obligated to report suspected child abuse or neglect to DFS at 1-800-292-9582.***

**Any other problems not mentioned above:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Check one of the following:

1. \_\_\_\_\_\_ Child Now has one of the problems listed above, but is currently receiving services to deal with them.
2. \_\_\_\_\_\_ Child NOW has at least one of the problems listed above and is not receiving services to deal with them.
3. \_\_\_\_\_\_ Child does not NOW have any of the problems listed above according to the screener.

Check one of the following:

1. \_\_\_\_\_\_ Child IN THE PAST had one of the problems listed above and has received services to deal with them.
2. \_\_\_\_\_\_ Child IN THE PAST had at least one of the problems listed above but has never received services to deal with them.
3. \_\_\_\_\_\_ IN THE PAST, child has not had any of the problems listed above according to the screener.

Screener Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_