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		
2. Suicidal gestures		
3. Suicide attempts requiring hospitalization		
4. Injures self, e.g., cutting, head-banging , burning, picking skin		
5. Homicidal – Statements of killing others		
6. Physically violent – Physically hurting others		
7. Verbally threatening - Threatening to hurt others		
8. Frequent, intense, uncontrollable temper tantrums		
9. Hallucinations (sees or hears things that aren't there)		
10. Delusions (has strong beliefs which have no basis in reality)		
11. Cruel to animals		
12. Willful destruction of property		
13. Fire setting		
14. Victim of physical Abuse confirmed/suspected		
15. Victim of Sexual Abuse confirmed/suspected		
16. Victim of Emotional Abuse confirmed/suspected		
17. Suspected or confirmed victim of caregiver neglect, e.g. failure to provide food, shelter or clothing.		
18. Inadequate or inappropriate parental supervision and/or discipline		
19. Exposure to Domestic Violence		
20. Wetting or Soiling (after potty training)		
21. Overly sensitive to environment (noise, touch) which causes distress		
22. Difficulty separating from parents, school refusal		
23. Recurrent intrusive thoughts or repetitive behaviors, such as hand washing, lock checking, organizing objects		
24. Persistent unrealistic worry over physical health		
25. Avoids people, places or things		
26. Always seems jumpy or afraid		
27. Gets upset when remembering bad thing that have happened to him/her.		
28. Many nightmares		
29. 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.		

30. 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		
31. Instability of residential arrangement, e.g., homelessness, multiple placements, frequent relocations		
32. Problems with same age peers		
33. Problems with family relationships or relationships with authority figures		
34. Inability to give or receive appropriate affection to primary caregivers		
35. Arrested, detained, or on probation		
36. Gambling		
37. Inappropriate sexual activity		
38. Running away		
39. Suspected or confirmed abuse of alcohol or other drugs/substances		
40. Confirmed or suspected developmental/Intellectual delay		
41. Problems in school/vocational activity (attendance, behavior, performance)		
42. Difficulty in concentration		
43. Excessive sadness, crying, withdrawal		
44. Easily angered or excessive anger.		
45. Excessive irritability		
46. Excessive fears or worries		
47. Irregular or problematic eating/appetite patterns		
48. 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						
2. Attempted Suicide						
3. Completed Suicide						
4. History of Mental Health Issues						
5. Current Mental Health Issues						
6. History of Substance Abuse						
7. Current Substance Abuse						
8. History of Incarceration						
9. Current Incarceration						
10. Domestic Violence						

Submission of this form <u>does not</u> 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:

A. _____ Child Now has one of the problems listed above, but is currently receiving services to deal with them.
B. _____ Child NOW has at least one of the problems listed above and is not receiving services to deal with them.
C. _____ Child does not NOW have any of the problems listed above according to the screener.

Check one of the following:

A. _____ Child IN THE PAST had one of the problems listed above and has received services to deal with them.
B. _____ Child IN THE PAST had at least one of the problems listed above but has never received services to deal with them.
C. _____ IN THE PAST, child has not had any of the problems listed above according to the screener.

Screener Signature: _____ Date: _____