PSYCHIATRIC CONSULTATION QUESTIONNAIRE
FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Please complete this questionnaire and bring it to the individual’s first appointment

A. IDENTIFYING DATA:
1. Name __________________________________________________________________________
2. Address __________________________________________________________________________
3. County of Registration ______________________________________________________________
4. Current residence: With parents □ on own □ other □ describe: _________________________________________________________________
5. Age _______ Date of Admission _______________________________________________________
6. Language Spoken ________________________________________________________________
7. How does the person communicate _____________________________________________

B. FORM COMPLETED BY:__________________________________________________________________________________
Position: ______________________________________________________________________________________________
Phone number: ___________________________ Date Completed: ________ / ________ / ________
month day year

C. ATTACH CURRENT ISP (Individual Support Plan) and HRP (Health Risk Profile) if available.

D. CHIEF COMPLAINT
Briefly state why this person is being referred for a psychiatric evaluation.
1. The person’s description of the problem is: _________________________________________________________________
2. Ongoing symptoms of ________________________________________________________________________________
3. New symptoms of _____________________________________________________________________________________

E. CURRENT SYMPTOMS EXHIBITED
1. Duration of current symptoms:
   _____ 1-3 months   _____ 3-6 months   _____ 6-12 months   _____ 12+ months
2. Behavioral pattern:
   _____ Problems are long term, i.e., individual behavior on a daily basis, but severity may wax and wane.
   _____ Problems are acute, i.e., behavior represents a dramatic change from his or her usual functioning and he/she has no history of a similar behavioral change.
   _____ Problems are episodic i.e., client has had periods of behavioral disturbance (lasting more than several days) interspaced with periods of normal functioning.
   Bring documentation if available.
F. FAMILY HISTORY OF MENTAL ILLNESS, DEVELOPMENTAL DISABILITIES, OR NEUROLOGICAL ILLNESS

List all biological relatives who have a history of mental illness, (such as depression, post partum depression, “nervous breakdown”), Autism, Fetal Alcohol Syndrome or neurological illness. Include periods of overt symptoms, suicide attempts, substance abuse, list psychiatric hospitalization, and/or treatment as evidence.

_____ no information available  _____ no family history of mental illness

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to individual</th>
<th>List diagnosis or associated behaviors for family members with mental illness, and/or neurological illness.</th>
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G. DEVELOPMENTAL DISABILITIES INFORMATION

1. Level of disabilities based on Psychological testing: List tests and dates
   (_____ no information available)
   _____ borderline intellectual function  _____ mild  _____ moderate  _____ severe  _____ profound  _____ unspecified

2. List limitations in adaptive functioning (i.e., communication, self care, social/interpersonal skills, self direction, etc.):
   __________________________________________________________________________________________________
   __________________________________________________________________________________________________
   __________________________________________________________________________________________________
   __________________________________________________________________________________________________
   __________________________________________________________________________________________________

3. Other Syndromes:
   ______ Angelman Syndrome
   ______ Down Syndrome
   ______ Fetal Alcohol Syndrome
   ______ Fragile-X Syndrome (Martin-Bell or Marker-X)
   ______ Lesch-Nyhan Syndrome
   ______ Prader-Willi Syndrome
   ______ Smith-Lemli-Optiz Syndrome
   ______ Smith-Magenis Syndrome
   ______ Velo-Cardio-Facial Syndrome
   ______ Williams Syndrome

H. CURRENT PSYCHIATRIC DIAGNOSIS – if any

   Axis I
   Axis II
   Axis III
   Axis IV
   Axis V
   GAF score if applicable
   Date of last psychiatric evaluation
I. MEDICAL HISTORY

1. Does individual have neurological problems? No □ Yes □ Describe ______________________________
Has individual had a CAT/MRI/PET scan?
No □ yes □ If yes, describe results or enclose report

2. Seizure disorder?
   No □ yes □ If yes, describe results or enclose report

<table>
<thead>
<tr>
<th>Seizure Type &amp; Description</th>
<th>Date of Last Seizure</th>
<th>Age of Onset</th>
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3. An abnormal EEG?
   No □ yes □ (attach report)

4. Has individual been diagnosed with a pervasive developmental disorder?
   No □ Yes □ If yes, describe or enclose reports:

5. Does individual have heart problems?
   No □ yes □ if yes, describe results or enclose report

6. Does individual have respiratory problems?
   No □ Yes □ if yes, describe results or enclose report
7. Does individual have stomach or intestinal problems?
   No □ yes □ if yes, describe results or enclose report

8. Include legible lab reports of the following tests— all blood and urine tests must have been completed within the past month.

   □ CBC
   □ TFT
   □ Folate
   □ Urinalysis
   □ SMA 6
   □ TSH
   □ VDRL
   □ EKG with interpretation
   □ SMA 12
   □ B12
   □ ESR
   □ Chem 7,
   □ CBC and Diff
   □ Calcium
   □ Magnesium
   □ RPR
   □ Phosphorous
   □ PT/INR
   □ AST
   □ Bilirubin, total
   □ ALT
   □ LDH
   □ Alk. Phosphotase
   □ TSH

9. Does individual have gynecological problems?
   No □ yes □ if yes, describe results or enclose report

10. Does individual have urinary problems?
    No □ yes □ if yes, describe results or enclose report

11. Does individual have endocrine disorders? (Diabetes etc.)
    No □ yes □ if yes, describe results or enclose report

12. Does individual have skin problems?
    No □ yes □ if yes, describe results or enclose report

13. Does individual have orthopedic problems?
    No □ yes □ if yes, describe results or enclose report

14a. Does individual have allergies?
    No □ yes □ if yes, describe results or enclose report
14b. **DRUG ALLERGIES/SENSITIVITIES**

List unusual or negative reactions to any type of drug therapy. (If stated “allergy,” describe the reaction and time frame.)

____________________________________________________________________________________________________
____________________________________________________________________________________________________
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____________________________________________________________________________________________________

14c. Has individual ever had Neuroleptic Malignancy Syndrome (NMS)?
   No □ yes □ if yes, describe results or enclose report

____________________________________________________________________________________________________
____________________________________________________________________________________________________

15. Does individual have dental issues?
   No □ yes □ if yes, describe results or enclose report

____________________________________________________________________________________________________
____________________________________________________________________________________________________

16. Does individual have problems with nose, throat, sinus?
   No □ yes □ if yes, describe results or enclose report

____________________________________________________________________________________________________
____________________________________________________________________________________________________

17. Does individual have impaired vision?
   No □ yes □ if yes, describe results or enclose report

____________________________________________________________________________________________________
____________________________________________________________________________________________________

18. Does individual have impaired hearing?
   No □ yes □ if yes, describe results or enclose report

____________________________________________________________________________________________________
____________________________________________________________________________________________________

19. Does individual have a specific communication disorder?
   No □ yes □ if yes, describe results or enclose report

____________________________________________________________________________________________________
____________________________________________________________________________________________________

Does the individual use adaptive communication equipment? Use Sign Language?
20. Has the individual experienced trauma or abuse?
   No □ yes □ if yes, describe results or enclose report

21. Does this individual have a history of substance abuse?
   No □ yes □ if yes, describe results or enclose report

22. Does this person have a condition that causes this person to experience pain?
   No □ yes □ if yes, describe results or enclose report
### J. Psychiatric Medication History

Please list all psychiatric medications: medications for Mental Illness, and Neurological, Behavioral Disorders. Start with Current Medications and go backwards.

<table>
<thead>
<tr>
<th>Medication And Dosage</th>
<th>Date started &amp; Discontinued</th>
<th>Target Symptoms</th>
<th>Diagnosis</th>
<th>Blood Levels</th>
<th>What was the response?</th>
<th>Reason For Discontinuation</th>
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<tbody>
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<td></td>
<td>Target Symptoms</td>
<td>Describe</td>
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<td>Better Worse Same</td>
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K. Medication History for Medical Problems
Please list all medications not for Mental Health, Neurological, and Behavioral Disorders. Include Over the Counter medication, cold medications, skin medications and vitamins.

<table>
<thead>
<tr>
<th>Medication And Dosage</th>
<th>Date started &amp; Discontinued</th>
<th>Target Symptoms</th>
<th>Diagnosis</th>
<th>Blood Levels</th>
<th>What was the response?</th>
<th>Reason For Discontinuation</th>
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L. CURRENT PHYSICAL FUNCTION
Consider the previous 3 months in completing this inventory and circle the indicated number if the problem has been present and indicate frequency

<table>
<thead>
<tr>
<th></th>
<th>None of the time</th>
<th>1-2 days/week</th>
<th>3-5 days per week</th>
<th>7 days per week</th>
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<tr>
<td>SLEEP - The individual: (Complete and include attached sleep chart)</td>
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<tr>
<td>1. Has difficulty falling asleep.</td>
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<td>2. Repeatedly awakens in the middle of the night.</td>
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<td>3. Awakens one hour or more before his or her time to get up and then remains awake for the rest of the day.</td>
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<td>4. Requires too little sleep.</td>
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<td>5. Requires an excess amount of sleep.</td>
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<td>6. Naps during the day.</td>
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<td>7. Nightmares</td>
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APPETITE - The individual has had:

|                                      |                  |               |                   |                |
| 1. A decrease in appetite.           |                  |               |                   |                |
| 2. A weight loss of more than 5 lbs. (attach weight chart) |                  |               |                   |                |
| 3. An increase in appetite           |                  |               |                   |                |
| 4. A weight gain of more than 5 lbs. |                  |               |                   |                |
| 5. a problem w/ overeating/under eating |                  |               |                   |                |

BOWEL/BLADDER FUNCTION - The individual has had:

|                                      |                  |               |                   |                |
| 1. Daytime urinary incontinence.    |                  |               |                   |                |
| 3. Daytime fecal incontinence        |                  |               |                   |                |

M. PROGRAM CHANGES

Have there been changes in the persons living arrangements or daily schedule?  No □ yes □ When?
Describe___________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

N. HISTORY OF RESIDENTIAL OR OUT OF HOME THERAPEUTIC INTERVENTIONS – Psychiatric and Medical

<table>
<thead>
<tr>
<th>Facility or Hospital</th>
<th>Patient Age</th>
<th>Dates of Stay</th>
<th>Diagnosis /Treatment (Presenting symptoms resulting in admission)</th>
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O. CURRENT THERAPEUTIC INTERVENTIONS – Including counseling, therapeutic rehabilitation, speech therapy, physical or occupational therapy, behavior support programs and 1:1 staff assignments

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Treatment Site</th>
<th>Response to Date</th>
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P. PROBLEM INVENTORY Related to Target Symptoms

Consider the previous 3 months in completing this inventory and circle the indicated number if the problem has been present and indicate frequency.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>None of the time</th>
<th>1-2 days/week</th>
<th>3-5 days per week</th>
<th>7 days per week</th>
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<tbody>
<tr>
<td>The individual:</td>
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<tr>
<td>1. Is self-injurious</td>
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<td>2. Eats non-food items (pica)</td>
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<td>3. Drinks excessive amounts of water</td>
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<td>4. Is overactive</td>
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<td>5. Is under active</td>
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<td>6. Engages in ritualistic behavior</td>
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<td>7. Has self-stimulatory Behavior</td>
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<td>8. Steals</td>
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<td>9. Has tantrums</td>
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<td>10. Is impulsive</td>
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<td>11. Is verbally aggressive</td>
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<td>12. Is physically aggressive</td>
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<tr>
<th>Sexuality</th>
<th>None of the time</th>
<th>1-2 days/week</th>
<th>3-5 days per week</th>
<th>7 days per week</th>
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<tbody>
<tr>
<td>The individual:</td>
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<tr>
<td>1. Publicly masturbates</td>
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<td>2. Inappropriately touches others</td>
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<td>3. Has attempted to coerce others into having sex</td>
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<td>4. Seems sexually driven or obsessed</td>
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<td>5. Engages in risky sexual behavior</td>
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<td>*Please be careful to differentiate between inappropriate sexuality and hyper sexuality</td>
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### Mood Changes

The individual:

1. Is excessively angry
2. Has periods of acute and precipitous anger
3. Is excessively irritable
4. Is overly anxious/fearful/worried
5. Has periods of acute fearfulness
6. Is easily startled
7. Is withdrawn
8. Appears sad
9. Cries easily
10. Is unable to enjoy activities
11. Is excessively elated/excited
12. Smiles without reason
13. Laughs without reason

### Form of Speech

The individual has:

1. An increased rate of verbalizations (rate even if functional language and he/she only vocalizes)
2. Speech that is echolalic (simply repeats what has been said to him or her)
3. Pressured speech, i.e., he/she is constantly verbalizing and doesn’t seem to be able to stop
4. Increased volume
5. Decreased volume

### Speech Content

The individual:

1. Is preoccupied with death
2. Talks of suicide
3. Is preoccupied with sexual themes
4. Talks of being harmed or attacked
5. Engages in conversations with people from his or her past
6. Boasts of plans and goals that far exceed his or her abilities

### Psychomotor Activity

The individual:

1. Is unable to sit still for more than a few minutes at a time
2. Moves slowly or remains motionless for long periods of time
Q. SLEEP CHART