Columbia University
Teen Screen Program
Mental Health Check-ups for Youth

Screening Summary Form (CHS)

Section I: Youth Information

Youth ID: _____

Age: _____

Date: ____/____/____

Sex: ☐ Female ☐ Male

Grade: ☐ 6th ☐ 7th ☐ 8th ☐ 9th
☐ 10th ☐ 11th ☐ 12th ☐ Not in School

Section II: CHS Summary Report

☐ Vision problem / hasn't seen doctor	☐ Hearing problem / hasn't seen doctor	☐ Dental problem / hasn't seen dentist

Q. 4 Nervous ☐ Bad Prob. ☐ Very Bad Prob. ☐ Want Help (a)	**Q. 9 Friends** ☐ Want Help (a)
Q. 5 Social Withdrawal ☐ Bad Prob. ☐ Very Bad Prob. ☐ Want Help (a)	
Q. 6 Unhappy ☐ Bad Prob. ☐ Very Bad Prob. ☐ Want Help (a)	
Q. 7 Irritable ☐ Bad Prob. ☐ Very Bad Prob. ☐ Want Help (a)	
Q. 8 Drugs / Alcohol ☐ Bad Prob. ☐ Very Bad Prob. ☐ Want Help (a)	**Q. 14 Reaction** ☐ More upset

Q. 10 Suicidal Ideation ☐ Yes ☐ No

Q. 11 Suicide Attempt ever ☐ Yes ☐ No

Section III: Screening Results & Next Steps

Positive screen if any one of these is checked:

☐ Q. **10** or Q.11 = **YES** (Suicide Ideation or Attempt)

☐ Any Question Qs. 4a thru 9a = **Want Help** (a)

☐ **3 Qs.** from Qs. 4 thru 8 = **Bad** or **Very Bad**

☐ Q. **14 = More Upset**

☐ Youth requests / program staff recommends clinical interview

☐ Youth refuses to answer Q(s). _____

Screen Results/Next Steps:

☐ Positive screen: **Requires** clinical interview

☐ Negative screen: **Does not require** clinical interview

Suicidal Behavior

Number of attempts / self-injurious acts in Lifetime: _____

Most RECENT Suicide Attempt	Most SERIOUS Suicide Attempt
Date	Date
Method: Planned / Impulsive: Certainty action would result in death (Intent): Disclosure / Discovery / Stopped self: Lethality / Medical attention: Stressors / Mood just prior to attempt: Substance use just prior to attempt:	Method: Planned / Impulsive: Certainty action would result in death (Intent): Disclosure / Discovery / Stopped self: Lethality / Medical attention: Stressors / Mood just prior to attempt: Substance use just prior to attempt:

Summary of Suicide Risk Assessment: _____

_____

Notes on Other Problem Areas: _____

_____

_____

_____

Current Psychosocial Stressors: _____

_____

Current Medical Conditions / Medications : _____

_____

Psychiatric History / Significant Medical History: _____

_____

Diagnostic Impressions: _____

_____

_____

Currently seeing a mental health professional? ☐ Yes ☐ No **Future appt. scheduled?** ☐ Yes ☐ No

If yes, for what? _____

Referral Recommended: ☐ Yes ☐ No **Emergency/Crisis:** ☐ Yes ☐ No

Reasons for Referral or Non-Referral: _____

_____

_____

Youth's Response to Referral: ☐ Accepted ☐ Denied ☐ Undecided ☐ Already In Treatment ☐ N/A

_____

_____

Clinician's Printed Name: _____

Clinician's Signature: _____ Date: _____

Section VI: Case Management & Follow-up

Date of Initial Contact with Youth: __ __/ __ __/ __ __ Date of Initial Contact with Parent: __ __/ __ __/ __ __

Parent's Response to Referral: ☐ Accepted ☐ Denied ☐ Undecided ☐ Youth Already In Treatment

Initial Appointment Scheduled? ☐ Yes ☐ No **Date Scheduled:** __ __/ __ __/ __ __

Youth Kept At Least One Appointment? ☐ Yes ☐ No **Date First Seen:** __ __/ __ __/ __ __

Initial Treatment Provider: _____

Services Received *Check all that apply:*

- ☐ School-Based Services
- ☐ Private Outpatient Care
- ☐ Emergency Room
- ☐ Partial Hospital Program
- ☐ Inpatient Unit
- ☐ Community Mental Health Center (CMHC) Outpatient Services
- ☐ Intensive Outpatient Program (IOP)
- ☐ Mobile Crisis
- ☐ Hospital-Based Psychiatric Clinic (outpatient)
- ☐ Other – Specify: _____

Date Case Closed: __ __/ __ __/ __ __ **Date Closing Letter Sent to Parents:** __ __/ __ __/ __ __

Reason for Closure: _____

Additional Case Management Notes: _____

_____

_____

Case Manager's Printed Name: _____

Case Manager's Signature: _____ Date: _____