**Hoosier Youth ChalleNGe Academy**
**10892 N State Road 140, Knightstown, IN 46148**
**Toll Free: 1-877-860-0003 Option: 2 / Fax: 765-345-1024**
**Website: in.gov/ago/hyca**

# Hoosier Youth ChalleNGe Academy
# Mental Health Questionnaire

This document needs to be filled out by a **licensed Mental Health Counselor/Therapist or Psychiatrist**. In place of this document, the Counselor/Therapist/Psychiatrist may write a brief statement on their letterhead, addressing the questions below. We need a representation of how stable or unstable the Patient's mental health is before we can grant admission. If you have any questions, please contact our Lead Nurse at 765-345-1014 or 317-938-8161.

PATIENT NAME: _____ DOB: _____

What diagnosis does the patient have that they see you for? _____

_____

How long have you been seeing this patient? _____

How often do you see the patient? _____

Does this patient take medications for their diagnosis? _____

If yes, what medications/doses are taken? _____

_____

Is the patient stable on medications? Have they had a medication change in the last 90 days?

_____

If yes, why was the medication changed? _____

_____

How would the patient do in a very structured routine, such as a Military Academy?

_____

_____

How does the patient handle being disciplined or corrected? _____

_____

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PATIENT NAME: _____ DOB: _____

What kind of reaction might we expect from the patient if they becomes stressed or overwhelmed?

_____

_____

Does the patient have any "triggers" that should be avoided? _____

_____

Does the patient have any sleep issues? _____

_____

Was the patient a victim of a traumatic event? _____

_____

Does the patient have a history of substance abuse issues? _____

_____

Does the patient have a history of self-harm, i.e. cutting?

_____

If yes, when was the last incident? _____

Has the patient ever been admitted for a Psychiatric Inpatient stay? _____

Please list dates and locations. _____

What was the issue presented at the time of admittance to Inpatient? _____

_____

_____

_____

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PATIENT NAME: _____ DOB: _____

Are there any other issues that we need to be aware of before accepting the patient into our Academy?

_____

_____

_____

_____

_____

Name of person filling out this form: _____

Signature: _____

Credentials: _____

Name, address and phone number of Office/Facility where you see the patient:

_____

_____

_____