

NEW JERSEY MENTAL HEALTH SCREENING TOOL (0 TO 5 YEARS)

Child's Name: _____ Date of Birth: _____

NJS: Case# _____ Person ID# _____

Casework/supv/contact info _____

Please check applicable boxes. Following each question are examples of behaviors or problems that would require a "YES" check. **Please circle any that apply.** This list is not exhaustive. If you have a question about whether or not to check "YES", please offer relevant information in the COMMENTS section.

YES	NO	Unknown	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><u>Behavior</u></p> <p>1. Does this child exhibit unusual or uncontrollable behavior?</p> <p>0 – 18 mos: Crying that is excessive in intensity or duration; persistent arching, "floppiness," or stiffening when held or touched; cannot be consoled by caregiver; cannot initiate or maintain sleep without extensive assistance in the absence of stressors such as noise or illness</p> <p>18 – 36 mos: Any of the behaviors above; extremely destructive, disruptive, dangerous or violent behavior; excessive or frequent tantrums; persistent and intentional aggression despite reasonable adult intervention; excessive or repetitive self-injurious behavior (e.g. head banging) or self-stimulating behavior (e.g. rocking, masturbation); appears to have an absence of fear or awareness of danger</p> <p>3 – 5 yrs: Any of the behaviors above; frequent night terrors; excessive preoccupation with routine, objects or actions (e.g. hand washing – becomes distraught if interrupted, etc.); extreme hyperactivity; excessively "accident-prone;" repeated cruelty to animals; lack of concern or regard for others; severe levels of problem behavior in toileting (e.g. encopresis, smearing) and aggression (e.g. biting, kicking, property destruction)</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>2. Does this child seem to be disconnected, depressed, excessively passive, or withdrawn?</p> <p>0 – 18 mos: Does not vocalize (e.g. "coo") cry or smile; does not respond to caregiver (e.g. turns away from his/her face; makes or maintains no eye contact; interaction with others does not appear to be pleasing); does not respond to environment (e.g. motion, sound, light, activity, etc.); persistent and excessive feeding problems.</p> <p>18 – 36 mos: Any of the above; fails to initiate interaction or share attention with other with whom s/he is familiar; unaware or uninvolved with surroundings; does not explore environment or play; does not seek caretaker/adult to meet needs (e.g. solace, play, object attainment); few or no words; fails to respond to verbal cues.</p> <p>3 – 5 yrs: Any of the above; does not use sentences of 3 or more words; speech is unintelligible; excessively withdrawn; does not play or interact with peers; persistent, extremely poor coordination of movement (e.g. extremely clumsy); unusual eating patterns (e.g. refuses to eat, overeats; repetitive ingestion of nonfood items); clear and significant loss of previously attained skills (e.g. no longer talks or is no longer toilet trained).</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>3. Has this child made statements or acted in ways that present a danger to self, other people, animals or property?</p> <p style="text-align: center;"><i>Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.</i></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><u>Placement, Childcare, Education Status</u></p> <p>4. Does this child exhibit behaviors that may not allow him/her to remain in his/her current living, preschool and/or childcare situation?</p> <p style="text-align: center;"><i>The child's behavior, and/or the caregiver's inability to understand and manage these behaviors, threaten the child's ability to benefit from a stable home environment, or preschool or childcare situation.</i></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><u>History</u></p> <p>5. Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in his/her home in the last 90 days?</p> <p style="text-align: center;"><i>Subjected to or witnessed serious physical abuse, domestic violence or sexual abuse, e.g., bruising in unusual areas, rarely held or responded to, forced to watch torture or sexual assault, witness to murder, etc.</i></p>

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If you checked any of the above boxes “YES”, child should be referred for assessment. For the young child, a next step will usually include a consult with the child’s pediatrician. Assessments may be completed by a pediatric neurologist, a neurodevelopmentalist, or a mental health professional. Please report your findings to the CHU nurse for assistance.

If applicable, identify the agency and provider to which the child has been referred:

COMMENTS/ADDITIONAL INFORMATION: _____
