**Child/Adolescent Pre-Treatment Questionnaire**

Clarity Counseling Associates

1D Commons Drive, Unit 23

Londonderry, NH 03053

Ph: 603-425-7600 Fax: 603-425-7605

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any long periods of time your child/teen has been out of school for any reason

including major illness, home-schooling, expulsion, etc.

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Child/teen lives with:

Name Sex (circle) Age Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male/ Female \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male/ Female \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Your child/teen’s primary care physician

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List any current medications, dosage, and reason:

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Have your child/teen received prior counseling or related services? (Circle one) Yes No

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Name of therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_ How long ago? \_\_\_\_\_\_\_

Problem(s) treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Outcome: (circle one): 1 2 3 4 5 6 7 8 9 10 Much worse Stayed the same Much better

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Name of therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_ (months/years) How long ago? \_\_\_\_\_\_\_

(months/years)

Problem(s) treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Outcome: (circle one): 1 2 3 4 5 6 7 8 9 10 Much worse Stayed the same Much better

If child has requested therapy, please allow him/her to answer the following questions, helping if needed.

Please check any of the reasons listed below which led you to seek treatment, choosing up to the 3 most important:

Regarding the most important reason that brings you here, please rate the following:

Issue 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does issue happen?

\_\_ Happens rarely \_\_ Happens 1-2 times a week \_\_ Happens 3-5 times a week \_\_ Happens daily \_\_ Happens several times a day

How does it affect your functioning?

\_\_ I can do all the things I need and want to do \_\_ I struggle a bit but am able to do all I need and want to do \_\_ I can only do some of the things I need and want to do \_\_ I can barely do the things I need to do \_\_ I am unable to work or care for myself

\_\_ Depression or anxiety \_\_ Worry about drinking or drug use \_\_ Communication problems \_\_ Arguing with parent(s) \_\_ Arguing with brothers/sisters \_\_ Sexual orientation questions \_\_ Problematic or too much anger \_\_ Feel alone/trouble making friends \_\_ Trouble controlling impulses \_\_ Difficulty with loss or death \_\_ Trouble staying organized \_\_ Trouble concentrating

\_\_ Thinking of hurting myself or someone else \_\_ Learning/memory problems \_\_ Family problems \_\_ Abuse (physical/sexual/emotional/verbal) \_\_ Trauma other than abuse (natural disaster, accident, crime witness, etc.) \_\_ Individual counseling \_\_ Family member wants me here \_\_ Getting in trouble at school \_\_ Learning problems \_\_ Trouble following directions \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Issue 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does issue happen?

\_\_ Happens rarely \_\_ Happens 1-2 times a week \_\_ Happens 3-5 times a week \_\_ Happens daily \_\_ Happens several times a day

How does it affect your functioning?

\_\_ I can do all the things I need and want to do \_\_ I struggle a bit but am able to do all I need and want to do \_\_ I can only do some of the things I need and want to do \_\_ I can barely do the things I need to do \_\_ I am unable to work or care for myself

Issue 3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does issue happen?

\_\_ Happens rarely \_\_ Happens 1-2 times a week \_\_ Happens 3-5 times a week \_\_ Happens daily \_\_ Happens several times a day

How does it affect your functioning?

\_\_ I struggle a bit but am able to do all I need and want to do \_\_ I can only do some of the things I need and want to do \_\_ I can barely do the things I need to do \_\_ I am unable to work or care for myself

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What questions do you hope will be answered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anything else you want the therapist or counselor to know before your first session?

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If the parent requested therapy or has additional information for managing a child/teen’s

behavior, parent should complete the following 4 questions.

Please check any of the reasons listed below that led you to seek treatment for your child, choosing the

most important:

Regarding the most important reason you are bringing your child here, please rate the following:

\_\_ Depression or anxiety \_\_ Worry about drinking or drug use \_\_ Communication problems \_\_ Child arguing with parent(s) \_\_ Child arguing with brothers/sisters \_\_ Sexual orientation questions \_\_ Problematic or too much anger \_\_ Feel alone/trouble making friends \_\_ Trouble controlling impulses \_\_ Difficulty with loss or death \_\_ Trouble staying organized \_\_ Refusing to attend school \_\_ Withdrawn

\_\_ Worry that he/she is suicidal \_\_ Child’s behavior is out of control \_\_ Abuse (physical/sexual/emotional/verbal) \_\_ Trauma other than abuse (natural disaster, accident, crime witness, etc.) \_\_ Trouble concentrating \_\_ Getting in trouble at school \_\_ Learning problems \_\_ Trouble following directions \_\_ Clingy/tearful \_\_ Verbally or physically aggressive \_\_ Trouble getting child to bed at night \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does issue happen? \_\_ Happens rarely \_\_ Happens 1-2 times a week \_\_ Happens 3-5 times a week \_\_ Happens daily \_\_ Happens several times a

How does it affect your child’s functioning?

\_\_ My child can do all the things he/she needs and wants to do \_\_ My child struggles a bit but is able to do all he/she needs and wants to do \_\_ My child can only do some of the things he/she needs and wants to do \_\_ My child can barely do the things he/she needs to do \_\_ My child is unable to take care of him/herself

How concerned are you? \_\_ Not concerned \_\_ A little concern \_\_ Moderately concerned \_\_ Very concerned \_\_ Paralyzed with concern

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Were there any difficulties with the pregnancy, birth, or early childhood of your child? If so, please

explain.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What questions do you hope will be answered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anything else you want the therapist or counselor to know?

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Person to contact in case of emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone numbers: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child/Teen Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_