Clarity Counseling Associates
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Londonderry, NH 03053
603.425.7600

Child/Adolescent Pre-Treatment Questionnaire

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.

_____

_____

_____

_____

Child/teen lives with:

Name	Sex (circle)	Age	Relationship
_____	Male/ Female	____	_____
_____	Male/ Female	____	_____
_____	Male/ Female	____	_____
_____	Male/ Female	____	_____
_____	Male/ Female	____	_____
_____	Male/ Female	____	_____
_____	Male/ Female	____	_____
_____	Male/ Female	____	_____

Your child/teen's primary care physician

_____

List any current medications, dosage, and reason:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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

****

Name of therapist: _____Where: _____

Length of treatment: _____ How long ago? _____

Problem(s) treated: _____

_____

Outcome: *(circle one):*

1 2 3 4 5 6 7 8 9 10

Much worse *Stayed the same* *Much better*

****

Name of therapist: _____Where: _____

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

(months/years)

Problem(s) treated: _____

_____

Outcome: *(circle one):*

1 2 3 4 5 6 7 8 9 10

Much worse *Stayed the same* *Much better*

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

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

__ 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: _____

__ 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

Regarding the **<u>most important</u>** reason that brings you here, please rate the following:

Issue 1 _____

<u>How often does issue happen?</u>

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

<u>How does it affect your functioning?</u>

__ 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 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

What questions do you hope will be answered? _____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

If the parent requested therapy or has additional information for managing a child/teen's behavior, parent should complete the following 4 question.

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

__ 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: _____

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

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 concerned are you?
__ Not concerned
__ A little concern
__ Moderately concerned
__ Very concerned
__ Paralyzed with concern

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

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

_____

_____

_____

What questions do you hope will be answered? _____

_____

_____

_____

_____

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

_____

_____

_____

_____

Person to contact in case of emergency: _____ Relationship: _____

Address: _____

Phone numbers: Home: _____ Work: _____ Cell: _____

Child/Teen Signature: _____ Date: _____

Parent/Guardian Signature: _____ Relationship:_____