Child/Adolescent Pre-Treatment Questionnaire

Clarity Counseling Associates
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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	____	___________________
____________________________	Male/ Female	____	___________________
____________________________	Male/ Female	____	___________________
____________________________	Male/ Female	____	___________________
____________________________	Male/ Female	____	___________________
____________________________	Male/ Female	____	___________________
____________________________	Male/ Female	____	___________________

Your child/teen's primary care physician

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List any current medications, dosage, and reason:

________________________ ____________ ____________________________________

______________________ ___________ _________________________________

______________________ ___________ _________________________________

______________________ ___________ _________________________________

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: ____

____

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: ____

____

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

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 question.

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:_______________