SHERMAN COUNSELING
Improving Quality of Life

Mental Health Services
Child/Adolescent Pre-Treatment Questionnaire

Please fill out as completely as you can and bring with you to your first therapy appointment. The information you provide is confidential and protected by law.

Name: _____ Parent/Guardian's Name_____

Address: _____

Phone Numbers: Home: _____ Work:_____ Cell: _____

1. Sex: __ Male __ Female 2. Age: ___ Years 3. School: _____ & Grade ____

4. 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. _____
_____

5. Child/teen lives with:

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

6. If child/teen is not living with one or both birth parents, what is the reason? _____
_____

7. Is your child/teen currently under a physician's care? (circle one) Yes No
If yes, name of physician and reason: _____
List any current medications and dosage: _____
_____
_____

8. Has your child/teen received prior counseling or related services? (circle one) Yes No

Name of therapist: _____ Where: _____
Length of treatment: _____mos./years How long ago? _____ mos./years 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: _____mos./ years How long ago? _____ mos./years ago
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 questions 9-12, helping if needed.

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

__ Depression / Anxiety
__ Worry about drinking 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 / 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:_____

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

Issue 1:

How often does issue happen?	How concerned are you?	How does it affect your functioning?
___ Rarely	___ Not concerned	___ I can do all things I need and want to do
___ 1-2 times a week	___ A little concern	___ I struggle but am able to do all I need and want to do
___ 3-5 times a week	___ Moderately concerned	___ I can do some things I need and want to do
___ Daily	___ Very concerned	___ I can barely do the things I need to do
___ Several times a day	___ Paralyzed with concern	___ I am unable to work/care for myself

Issue 2:

How often does issue happen?	How concerned are you?	How does it affect your functioning?
___ Rarely	___ Not concerned	___ I can do all the things I need and want to do
___ 1-2 times a week	___ A little concern	___ I struggle but am able to do all I need and want to do
___ 3-5 times a week	___ Moderately concerned	___ I can do some things I need and want to do
___ Daily	___ Very concerned	___ I can barely do the things I need to do
___ Several times a day	___ Paralyzed with concern	___ I am unable to work/care for myself

Issue 3:

How often does issue happen?	How concerned are you?	How does it affect your functioning?
___ Rarely	___ Not concerned	___ I can do all the things I need and want to do
___ 1-2 times a week	___ A little concern	___ I struggle but am able to do all I need and want to do
___ 3-5 times a week	___ Moderately concerned	___ I can do some things I need and want to do
___ Daily	___ Very concerned	___ I can barely do the things I need to do
___ Several times a day	___ Paralyzed with concern	___ I am unable to work/care for myself

11. What questions do you hope will be answered? _____
_____
_____
_____

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

Please check any symptoms you may be experiencing (even if they are in more than one place)

A
__ Poor appetite / weight loss
__ Overeating / weight gain
__ Difficulty sleeping
__ Sleeping too much
__ Feelings of worthlessness
__ Crying spells
__ Low self-esteem
__ Sadness / Loneliness
__ Difficulty making decisions
__ Trouble concentrating
__ Irritability
__ Feelings of hopelessness
__ Suicidal Thoughts
__ Suicidal Plan
__ History of suicide attempts
__ Homicidal Thoughts
__ Lack of interest / motivation
__ Loss of enjoyment in activities
__ Isolating from family / friends
__ Poor self-care / cleanliness

B
__ Muscle Tension
__ Restlessness
__ Trouble concentrating
__ Worry too much
__ Tire easily

C
__ Racing heartbeat
__ Tightness in chest
__ Fear of having heart attack/dying
__ Chills / Hot flashes
__ Difficulty breathing
__ Fear of loss of control/going crazy
__ Numbness or tingling sensations

D
__ Headaches
__ Stomach aches
__ Menstrual problems
__ Frequent pain

E
__ Excessive spending
__ Racing thoughts
__ Talking too fast
__ High Risk activities
(business / financial / sexual etc.)
__ Very little sleep (2-3 hrs of sleep)

F
__ Shoplifting / Stealing
__ Gambling
__ Debt / relationship issues
__ Use of alcohol / drugs

G
__ Binge eating
__ Regular use of laxatives
__ Excessive exercising
__ Self-induced vomiting
__ Self-mutilation

Other:
_____
_____
_____

H
__ Inattentive
__ Careless
__ Forgetful
__ Disorganized
__ Easily Distracted
__ Trouble listening
__ Avoids mental tasks
__ Often lose things
__ Feel driven / on the go
__ Talk excessively
__ Fidget a lot
__ Often interrupt / blurt out answers
__ Impulsive

I
__ Nightmares
__ Recurrent/stressful thoughts of past trauma
__ Acting / feeling of re-experiencing past trauma
__ Startled easily
__ Anger outbursts

J
__ Often angry
__ Physically aggressive
__ Swear / name call during arguments
__ Throw or break things

If the parent requested therapy or has additional information for managing a child/teen's behavior, parent should complete questions 13-16.

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

__ Depression / Anxiety
__ Worry about Drinking / 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 / death
__ Trouble staying organized
__ Refusing to attend school
__ Trouble concentrating
__ Withdrawn
__ Thinking of hurting themselves or someone else
__ Behavior is out of control
__ Learning / memory problems
__ Family problems
__ Abuse (physical / sexual / emotional / verbal)
__ Trauma other than abuse (natural disaster/accident/crime witness)
__ Individual counseling
__ Family member wants me here
__ Getting into trouble at school
__ Learning problems
__ Trouble following directions
__ Clingy / tearful
__ Verbally / physically aggressive
__ Trouble getting child to bed at night
__ Other: _____

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

Issue:

How often does issue happen?	How concerned are you?	How does it affect your functioning?
___ Rarely	___ Not concerned	___ I can do all the things I need and want to do
___ 1-2 times a week	___ A little concern	___ I struggle but am able to do all I need and want to do
___ 3-5 times a week	___ Moderately concerned	___ I can do some things I need and want to do
___ Daily	___ Very concerned	___ I can barely do the things I need to do
___ Several times a day	___ Paralyzed with concern	___ I am unable to work/care for myself

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

16. What questions do you hope will be answered? _____
_____
_____
_____

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

Please check any symptoms he / she may be experiencing (even if they are in more than one place)

A
__ Poor appetite / weight loss
__ Overeating / weight gain
__ Difficulty sleeping
__ Sleeping too much
__ Feelings of worthlessness
__ Crying spells
__ Low self-esteem
__ Sadness / Loneliness
__ Difficulty making decisions
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__ Suicidal Thoughts
__ Suicidal Plan
__ History of suicide attempts
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__ Loss of enjoyment in activities
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__ Trouble concentrating
__ Worry too much
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J
__ Often angry
__ Physically aggressive
__ Swear / name call during arguments
__ Throw or break things

18. Who referred you to our clinic's Mental Health Services? _____

19. Person to contact in case of emergency: _____

Relationship: _____ Address: _____

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

20. Child/Teen Signature: _____ Date: _____

Parent/Guardian Signature: _____ Relationship: _____