SHERMAN COUNSELING

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	____	_____

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

1. 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	

2. 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)*
__ Individual Counseling
__ Family Member wants me here
__ Getting into 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 dose this 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 concerned	__ I struggles 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 dose this 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 concerned	__ I struggles 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 dose this 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 concerned	__ I struggles 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 hours 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/teens 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 dose this 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 concerned	__ I struggles 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
__ 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

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__ Muscle Tension
__ Restlessness
__ Trouble Concentrating
__ Worry too much
__ Tire easily

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__ Racing heartbeat
__ Tightness in chest
__ Fear of having heart attack / dying
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__ Binge Eating
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Other :
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J
__ Often angry
__ Physically Aggressive
__ Swear / name call during arguments
__ Throw or break things

18. How did you hear about us? _____

19. Emergency Contact: _____ Phone number:_____
Relationship: _____
Address:_____

20. Child/Teen Signature: _____ Date:_____

Parent/Guardian Signature: _____ Relationship:_____