DARING MINDS
therapy

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Child / Adolescent Pre-Treatment Questionnaire

Name:	Today's Date:
Birthdate:	Age:
Gender:	Ethnicity:

Demographic Information:

Name of person completing form: _____ Relationship to client: _____

Who does the client currently reside with? _____

What city and state was the client born in? _____

What city and state was the client primarily raised in? _____

How long has the client lived at the address you provided us? _____

Would you consider their housing to be: Stable Unstable If unstable, please describe: _____

_____

Please choose the one that best describes the current housing arrangement for this child:

□ Parent/Guardian owns the home

□ Parent/Guardian rents the home

□ Child and family lives with relatives/friends (temporary)

□ Child and family lives with relatives/friends (permanent)

□ Homeless □ Transitional □ Emergency Shelter

How long has this child lived in the current living situation? _____

How many times has the child moved in the past two years? _____

Foster Care Involvement

Has your child ever been in foster care? □ Yes □ No □ Unknown

From _____ age to _____ age Reason: _____

Type of Placement: □ Kinship Placement □ Agency Placement

Current Status: □ In-care □ Out of Care

If out of care, reason for leaving: □ Adopted □ Returned to Home □ Emancipated
□ Ran away from care □ Other: _____

Presenting Problem (Briefly describe the issues/problems which led to your decision to seek our services)

_____

_____

_____

Presenting Problem Categorization: (Please check all that apply and circle the description of the symptom)

Symptoms causing concern, distress, or impairment:

□Change in sleep patterns (please check): sleeping more sleeping less difficulty falling asleep
difficulty staying asleep difficulty waking up difficulty staying awake nightmares

□Concentration: Decreased concentration Increased or excessive concentration

□Change in Appetite: Increased appetite Decreased appetite

□Increased Anxiety (describe): _____

□Mood Swings (describe): _____

□Behavioral Problems / Changes (describe):

_____

_____

□Victimization (please circle): physical abuse sexual abuse psychological abuse
neglect witnessed domestic violence witnessed physical assault bullying

Other (please describe other concerns):

_____

_____

How long has this problem been causing your child distress? (please circle)

One week One month 1-6 months 6 months- 1 year Longer than 1 year

Pregnancy & Birth History

Were there any complications during pregnancy? □Yes □No If yes, please explain: _____

_____

□Full-term Birth □Premature Birth

Were there complications during birth? □Yes □No If yes, please explain: _____

_____

Were drugs or alcohol consumed during pregnancy? □Yes □No

Child's health at birth? _____

Was your child adopted? □Yes □No If yes, what age? _____

□Domestic adoption □International adoption (Country: _____)

Developmental History:

As accurately as you can remember, how old was your child when she/he:

Rolled over? _____ Crawled? _____ Walked? _____ Talked (two words)? _____ Toilet Trained? _____

Do/did you have concerns about your child's development in any of these areas (below)?

□Speech/language □Motor Skills □Cognitive/Intellectual □Sensory □Behavioral □Emotional □Social

If so, please describe: _____

_____

Were there any significant disturbances/changes during your child's childhood? □Yes □No

If yes, please describe: _____

_____

_____

Physical Medical History

How would you describe your child's overall health: □ Poor □Fair □Good □Excellent

Has your child ever been hospitalized overnight? □Yes □No

If so, how many times? ____

When was their most recent hospitalization? _____

What was it for? _____

Does your child currently have any physical medical conditions? □Yes □No

If yes, what?

_____

_____

Is your child currently prescribed any medications for a physical medical reason? □Yes □No

If yes, please list:

_____

_____

Who is your child's Primary Care Physician or Medical Doctor? _____

When was your child's last physical examination? _____

Is your child up to date on vaccinations? □Yes □No

Does your child have any allergies to medications or environmental factors? □ no □ yes

If so, to what? _____

Any family history of the following? (Please circle all that apply.)

Asthma	visual impairment	obesity
Diabetes	hearing impairment	miscarriage / stillbirth
Ulcers	physical disability	menstrual problems
Blood pressure problems	seizures	fertility problems
Heart condition	migraines/headaches	difficult pregnancies
High cholesterol	head injury	abortion
Stomach/bowel problems	chronic pain	cancer
Thyroid problems	arthritis	allergies
Fibromyalgia	sexually transmitted disease	

Other, please specify:

If you circled any of the above medical items, please explain:

_____

_____

_____

Education / Social History

What grade is your child currently in? _____

What is the name of their school? _____

How would you describe your child's attendance (currently)? (circle ALL that apply)

Regularly attending Some truancy Alternative School Suspended Expelled

What kind of grades do they get? _____

How would you describe your child's attitude towards school/education? _____

Do they have an IEP or 504 plan? □Yes □No If yes, what for? _____

Are there any disciplinary or behavioral issues at school? □Yes □No

What kinds of clubs, activities, or sports are they involved in? _____

_____

Who do they spend the majority of their spare time with? _____

Do you have any concerns about their peer / social group? □ Yes □ No

If yes, please explain: _____

_____

Alcohol / drug history

Please list age of first use and age of last use for the following substances:

Substances:	First Use:	Last Use:	Frequency:	Quantity:
Tobacco				
Alcohol				
Marijuana				
Cocaine / crack				
Methamphetamine				
Hallucinogens				
Opiates				

What is your drug of choice? _____

Have you ever been voluntarily abstinent form your drug of choice? _____

When? _____ How long? _____

Have you ever had any counseling or treatment for substance abuse? No Yes

If yes, please list when, where, and what type of treatment: _____

Have you ever used a needle to administer drugs? No Yes

If yes, when was the last time? _____

Have you ever overdosed on drugs? No Yes

If yes, how many times? _____ when was the last time? _____

How much money have you spent in the last thirty days on: $ _____ alcohol $_____ drugs

Do any family members smoke? _____

Family Composition:

Biological Mother's Name: _____Age: _____

Living with child Not living with child Employed currently? Yes No

Place of Employment: _____ Occupation: _____

Biological Father's Name: _____ Age: _____

Living with child Not living with child Employed currently? Yes No

Place of Employment: _____ Occupation: _____

Marital status of Parents: Never a couple Married Divorced Widowed Domestic Partnership

Current caregivers (if applicable): _____

Please list the names, ages, relationships, and other relevant information regarding all immediate family members whether living in- or outside the home. Please include all members currently residing in child's household:

Name	Gender	Age	Relationship to client	Living with Child
				□Yes □No
				□Yes □No
				□Yes □No
				□Yes □No
				□Yes □No
				□Yes □No

Parent/Child Relationship

Describe parenting your child (e.g. challenging, easy): _____

What do you find most challenging in parenting your child? _____

What kind of discipline works best with your child? _____

Psychiatric/Psychological History

Has your child ever previously been in therapy or seen a psychologist or psychiatrist? □Yes □No

If yes, please explain: _____

_____

Is your child currently being seen by a counselor? □Yes □No

If yes, name of current counselor _____ Length of treatment _____

Is your child currently being seen by a psychiatrist? □Yes □No

If yes, name of current psychiatrist _____ Length of Treatment _____

Is your child currently prescribed any medication? □Yes □No

If yes, please complete the following:

Medication Name	Dose

Has your child ever been diagnosed with a mental health, emotional or psychological condition?

□Yes □No

If yes, what diagnosis was your child given? _____

When? _____

By whom? _____

Has your child been hospitalized for mental health or drug and alcohol concerns in the past? □Yes □No

If yes, please explain: _____

_____

_____

_____

Safety Concerns

Is your child presently suicidal? □Yes □No If yes, please explain: _____

Has your child ever attempted to commit suicide? □Yes □No If yes, when and how? _____

_____

Is there a history of suicide in your child's immediate and/or extended family? □Yes □No

If yes, please explain _____

_____

Has your child ever inflicted burns, cuts, or any type of wound on his/herself? □Yes □No

Additional information: (please list any additional information as needed to address past and current safety issues)

_____

_____

_____

Has your child ever been □ physically, □ emotionally, or □ sexually abused? (please check all that apply)

Family Mental Health History

Please identify if any members of your family have had a history of any of the following mental health/drug abuse/ legal concerns. (If your child is adopted or you are their foster care provider, do not fill out)

Family History	Depression	Anxiety	Bipolar Disorder	Schizophrenia	ADHD	Trauma History	Abusive Behavior	Drug Abuse	Alcohol Abuse	Incarceration
Self										
Mother										
Father										
Sister										
Brother										
Maternal Uncle										
Paternal Uncle										
Maternal Aunt										

Paternal Aunt										
Maternal Grandmother										
Paternal Grandmother										
Maternal Grandfather										
Paternal Grandfather										
Biological Child										

Strengths / Resources / Supports:

What limitations does your child/family have (if any)? _____

What strengths does your family/child have? _____

What resources does your child have to help with their current problem?

_____

What are you and your family already doing to improve the current situation?

_____

What else should we be aware of?

_____

_____

_____