Alphabet Shuffle, LLC

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: __________________________ 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

<u>**If child has requested therapy, please allow him/her to answer questions 9-12, helping if needed.**</u>

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

__ 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

__ 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

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?
__ Happens rarely	__ Not concerned	__ I can do all the things I need and want to do
__ Happens 1-2 times a week	__ A little concern	__ I struggle a bit but am able to do all I need and want to do
__ Happens 3-5 times a week	__ Moderately concerned	__ I can only do some of the things I need and

Issue 2 (including rating)

Issue 3 (Including rating)

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? ___________________
____
____
____

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 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

__ 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

14. 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

How concerned are you?

__ Not concerned

__ A little 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

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

____

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? ________________

____
____
____

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

19. Person to contact in case of emergency: ____

Relationship: ________________ Address: ____________________________________

Phone numbers: Home: _________________________ Cell: ____________________

20. Child/Teen Signature: ___________________________________ Date: _____________

Parent/Guardian Signature: _____________________________ Relationship: ____________