BOYS TOWN

Behavioral Health Clinic
Pretreatment Questionnaire

Client Name: _____ DOB: _____ Date: _____ M ☐ F ☐

Race: American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐
Native Hawaiian or Other Pacific Islander ☐ Other ☐ Decline to Answer ☐

Ethnicity: Hispanic or Latino Origin ☐ Not Hispanic or Latino Origin ☐ Decline to answer ☐ Unknown ☐

Form completed by: Self ☐ Parent ☐ Other ☐ _____
Relationship to client

Referred by: Physician ☐ Employer ☐ Relative ☐ Friend ☐ Website ☐
Other: ☐ _____

Primary concern(s) for which treatment is sought: _____

1. Please rate your child on each of the areas below AND whether it has been a problem during the last month:

	Extremely Poor			OK			Extremely Well	Is this a problem?	
Getting along with family	1	2	3	4	5	6	7	Yes	No
Getting along with other peers/children outside of the home	1	2	3	4	5	6	7	Yes	No
Getting along with other adults outside of the home	1	2	3	4	5	6	7	Yes	No
Performance at school/work	1	2	3	4	5	6	7	Yes	No

2. Please rate your child on each of the areas below AND whether it has been a problem during the last month:

	Never			Sometimes			Always	Is this a problem?	
Overactive, acts without thinking	1	2	3	4	5	6	7	Yes	No
Sad, unhappy, down, or depressed	1	2	3	4	5	6	7	Yes	No
Worried, nervous, and/or anxious	1	2	3	4	5	6	7	Yes	No
Difficulties with school (academics and/or behavior)	1	2	3	4	5	6	7	Yes	No
Sleeping problems	1	2	3	4	5	6	7	Yes	No
Problems with temper, having a 'short fuse'	1	2	3	4	5	6	7	Yes	No
Difficulty tolerating frustration/change	1	2	3	4	5	6	7	Yes	No
Problems with peers	1	2	3	4	5	6	7	Yes	No
Other: _____	1	2	3	4	5	6	7	Yes	No
Other: _____	1	2	3	4	5	6	7	Yes	No

Clinician Use:		Int		Ext		Comb		Oth

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Individuals living with child/youth:

Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

Divorced/Separated/Not Living Together: No ☐ Yes ☐ If yes, please note above who (adults and children) lives with your child in each residence. Also, please describe current parenting schedule/time spent in each household: _____

Educational history:

Current school: _____ Current grade: _____
Special education placement? No ☐ Yes ☐ If yes, in what area? _____
Has the school performed psychological testing? No ☐ Yes ☐ If yes, when? _____
Is there an IEP (Individual Educational Plan)? No ☐ Yes ☐ Don't know ☐ _____

Child's interests/activities: _____

What are your child's strengths? _____

Previous mental health treatment: No ☐ Yes ☐ If yes, please detail below:

Mo/Yr _____ Provider _____ Treatment _____ Outcome _____
Mo/Yr _____ Provider _____ Treatment _____ Outcome _____

Current legal concerns: No ☐ Yes ☐ If yes, please explain: _____

Past History of abuse: No ☐ Yes ☐ If yes, please explain: _____

Religious/spiritual affiliation(s): _____ None ☐ Prefer not to answer ☐

Developmental history:

Complications at birth or in early childhood? No ☐ Yes ☐ If yes, please explain: _____

Medical diagnoses and conditions: None ☐ Yes ☐ List: _____

Significant operations/invasive procedures None ☐ Yes ☐ List: _____

Serious injuries/chronic illnesses/hospitalizations: None ☐ Yes ☐ List: _____

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Last visit to doctor/well-check date: _____ Doctor's name: _____

Allergies: None ☐ Yes ☐ List: _____

Immunizations current Yes ☐ No ☐ If no, please explain _____

Medications (prescribed and over-the-counter): None ☐

Medication _____ Dosage _____ Prescribing Physician _____ Started _____
Medication _____ Dosage _____ Prescribing Physician _____ Started _____
Medication _____ Dosage _____ Prescribing Physician _____ Started _____
Medication _____ Dosage _____ Prescribing Physician _____ Started _____
Date of last medication check. _____

Adverse drug reactions: None ☐ Other ☐ _____

Substance use:

Alcohol Use: None ☐ Suspected ☐ Known to use currently ☐ Recovering ☐
Type: _____ Amount: _____ How often? _____

Drug Use: None ☐ Suspected ☐ Known to use currently ☐ Recovering ☐
Type: _____ Amount: _____ How often? _____

Client Name (if not a minor)		Signature of Client	Date
Legal Guardian Name (Print)	Relationship (e.g., mother, father, etc.)	Signature of Legal Guardian	Date