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