



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

Referred by: Physician Employer Relative Friend Website
 Other: _____
Relationship to client

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?	
	1	2	3	4	5	6	7	8	9	Yes	No
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?	
	1	2	3	4	5	6	7	8	9	Yes	No
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
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