



## 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?	
	1	2	3	4	5	6	7	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	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