NEW ENGLAND PASTORAL INSTITUTE, INC.

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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: _____ Work:_____ Cell: _____ Date of Birth: _____

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	Gender(circle)	Age (list)	Primarily living in your home?
_____	M F	____	Yes No
_____	M F	____	Yes No
_____	M F	____	Yes No
_____	M F	____	Yes No
_____	M F	____	Yes No
_____	M F	____	Yes No

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

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

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

__ 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
__ Feel alone/trouble making friends
__ Trouble controlling impulses
__ Difficulty with loss or death
__ Trouble staying organized
__ Trouble concentrating
__ 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
__ Family member wants me here
__ Getting in trouble at school
__ Learning problems
__ Trouble following directions
__ Other: _____

10. Regarding the **most important** reason that brings you here, please rate the following:

Issue 1. _____

How often does issue happen?
__ Happens rarely
__ Happens 1-2 times a week
__ Happens 3-5 times a week
__ Happens daily
__ Happens several times a day

How does it affect your functioning?
__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I need and want to do
__ I can only do some of the things I need and want to do
__ I can barely do the things I need to o
__ I am unable to work or care for myself

How concerned are you?
__ Not concerned
__ A little concern
__ Moderately concerned
__ Very concerned
__ Paralyzed with concern

Issue 2. _____

How often does issue happen?
__ Happens rarely
__ Happens 1-2 times a week
__ Happens 3-5 times a week
__ Happens daily
__ Happens several times a day

How does it affect your functioning?
__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I need and want to do
__ I can only do some of the things I need and want to do
__ I can barely do the things I need to do
__ I am unable to work or care for myself

How concerned are you?
__ Not concerned
__ A little concern
__ Moderately concerned
__ Very concerned
__ Paralyzed with concern

Issue 3. _____

How often does issue happen?
__ Happens rarely
__ Happens 1-2 times a week
__ Happens 3-5 times a week
__ Happens daily
__ Happens several times a day

How does it affect your functioning?
__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I need and want to do
__ I can only do some of the things I need and want to do
__ I can barely do the things I need to do
__ I am unable to work or care for myself

How concerned are you?
__ Not concerned
__ A little concern
__ Moderately concerned
__ Very concerned
__ Paralyzed with concern

11. What questions do you hope will be answered? _____
_____
_____
_____

12. Is there anything else you want the therapist 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
__ Trouble controlling impulses
__ Difficulty with loss or death
__ Trouble staying organized
__ Refusing to attend school
__ Withdrawn
__ Learning/memory problems
__ 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
__ Learning problems
__ Trouble following directions
__ Clingy/tearful
__ Verbally or physically aggressive
__ Trouble getting child to bed at night
__ Other: _____

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
__ Happens daily
__ Happens several times a day

How concerned are you?
__ Not concerned
__ A little concern
__ Moderately concerned
__ Very concerned
__ Paralyzed with 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
__ My child can only do some of the things he/she needs and wants to do
__ My child can barely do the things he/she needs to do
__ My child is unable to take care of him/herself

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

_____
_____
_____

16. Who referred you to the New England Pastoral Institute? _____

17. Person to contact in case of emergency: _____
Relationship: _____ Address: _____
Phone numbers: Home: _____ Work: _____ Cell: _____

18. Child/Teen Signature: _____ Date: _____
Parent/Guardian Signature: _____ Relationship: _____