PATHWAYS
COUNSELING CENTER

11121 W. Oklahoma Ave
West Allis, WI, 53227
P (262) 641-9790
F (262) 641-9791

Child/Adolescent Pre-Treatment Questionnaire

To better assess if we can meet your family's needs, please fill out as completely as you can and bring with you to your first therapy appointment. Use additional sheets of paper as needed. The information you provide is confidential and protected by law. We look forward to meeting you.

Date Completed: _____

Name: _____ **Parent/Guardian's Name:** _____

1. Gender: _____ **2.** Age: _____ Years **3.** School: _____ Grade: _____

4. Ethnicity: _____ **5.** Religion: _____

6. 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.

_____

7. Child/teen lives with:

Name	Gender	Age (list)	Relationship

8. If child/teen is not living with one or both birth parents, what is the reason? _____

_____

9. Is your child/teen currently under a physician's care? (circle one) YES NO Date of last physical exam: _____

List any physicians, **current medical conditions**, medications, and dosage. (Add on the back if needed.)

Condition	Medication	Dosage	Physician

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10. Has your child received prior counseling or related services? (circle one) YES NO

Name of therapist: ______________________ Where: ______________________

Length of treatment: ________ months/years How long ago? ________ Months/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: ________ months/years How long ago? ________ Months/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: ________ months/years How long ago? ________ Months/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

11. When thinking about your child (or yourself if you are the patient), do they/you have past or current experiences of abuse of any kind, including physical, emotional, verbal, or sexual? Please share below or with your therapist.

____

____

____

____

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12. Please describe **current** substance use/abuse in the chart below. **Please mark N/A if not applicable.**

	Typical Frequency of Use in Past 6 Months					**Time of Last Use**		
	Daily	1-6 Times A Week	Weekend Use Only	Few Times/ Month	Once a Month or Less	Within Past Week	Within Past Month	Over 1 Month Ago
Alcohol								
Marijuana								
Cocaine (Powder, Crack)								
Amphetamines (Crystal Meth)								
Sedatives								
Minor Tranquilizers (Valium)								
Hallucinogens								
Barbiturates								
Heroin								
Other Opiates/Narcotics								
Inhalants								
Nicotine (Cigs, Vape)								
Caffeine								
Other: _____								

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13. In general, how much of a problem do you think your child has with the following?

	1 = least				5 = most
	1	2	3	4	5
Family member wants me here					
Family problems					
Getting into trouble					
Getting along with his/her mother					
Getting along with his/her father					
Arguing with parent(s)					
Trouble following directions					
Getting along with adults other than his/her caregiver(s)					
Getting involved in activities like sports or hobbies					
Feel alone/trouble making friends					
Sexual orientation questions					
Gender identity questions					
Having fun					
Getting along with his/her sibling(s)					
Arguing with sibling(s)					
Getting along with other children his/her age					
Trouble staying organized					
Trouble concentrating					
Difficulty with loss or death					
Trouble controlling impulses					
Problematic or too much anger					

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(Continued) In general, how much of a problem do you think your child has with the following?					
	1= least				5= most
	1	2	3	4	5
Learning/memory problems					
Abuse (physical/emotional/verbal/sexual)					
Trauma other than abuse (natural disaster, accident, crime witness, etc.)					
Feeling unhappy or sad					
Feeling nervous or worried					
Depression or anxiety					
Thinking of hurting self or someone else					
His/her behavior at school (or at work)					
Getting in trouble at school					
Learning his/her schoolwork (or doing his/her job) problems					

14. How much has your child's behavior caused:

	1 = a little				5 = a lot
Interruption of personal time?	1	2	3	4	5
Disruption of family routines?					
Any family member having to do without things?					
Any family member to suffer negative mental or physical health?					
Financial strain for the family?					
Less attention paid to any family member because of attention given to your child?					
Disruption or upset relationships within your family?					
Disruption of family's social activities?					
You to miss work or neglect duties?					

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

_____

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

_____

17. Is there anything else you want the therapist or counselor to know before the first session? _____

_____

18. Who referred you to Pathways Counseling Center? _____

19. To get a better understanding of your child's symptoms, please complete the table below and bring to the first therapy appointment. Over the last 2 weeks, how often has your child been bothered by the following symptoms?

	Never	Several days	More than half the days	Daily
Sadness, hopelessness, feeling down				
Poor appetite or overeating; weight loss or gain				
Loss of interest or pleasure in doing things				
Fatigue or loss of energy				
Feeling bad about themselves – that they are a failure or have let themselves or your family down				
Trouble concentrating, making simple decisions				
Thoughts of death or suicide				
Trouble falling asleep or staying asleep, restless and unsatisfying sleep, or sleeping too much				
	Never	Several days	More than half the days	Daily
Restlessness, feeling keyed-up, or on edge				
Being easily tired				
Problems concentrating or mind goes blank				
Irritability				
Muscle tension				
Trouble falling or staying asleep, or restless and unsatisfying sleep				
	Never	Several days	More than half the days	Daily
An intense and persistent fear of a social situation in which people might judge them				
Fear that they will be humiliated by their actions				
Fear that people will notice that they are blushing, sweating, trembling, or showing other signs of anxiety				
Knowing that their fear is excessive or unreasonable				

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Please provide any other information that you feel is important for the therapist to know:

Signature: _____ Date: _____