Children's Therapy Network LLC

MENTAL HEALTH THERAPY QUESTIONNAIRE

1. Please list the reason for seeking mental health therapy: _____
_____
_____
_____

2. Please list all of the client's known current and past mental health diagnoses:

Diagnosis:	Diagnosed by:	Diagnosis date:

3. Please list the client's psychoactive medications and dosages:

	Medication #1	Medication #2	Medication #3
Medication Name(s):			
Medication purpose(s):			
Dosage(s):			
Prescribing doctor:			
Date of last medication check:			

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4. Please describe any current or past mental health treatment (please include name(s) of therapist/counselor/psychiatrist and date treatment began and/or ended):

_____
_____
_____
_____
_____

5. How did the client/family respond to past treatment?

_____
_____
_____
_____
_____

6. Please check any of the symptoms listed below that led you to seek treatment for the client, bolding or circling the **most important:**

- ☐ Depression or anxiety
- ☐ Appetite/feeding concerns (ie: eating too much, too little, only eats certain foods)
- ☐ Decreased or lack of energy
- ☐ Fears or phobias: _____
- ☐Worry about drinking or drug use
- ☐Communication problems
- ☐Client arguing with parent(s)
- ☐Client arguing with sibling(s)
- ☐Sexual orientation questions
- ☐ Concerning sexual behaviors or language
- ☐Problematic or too much anger
- ☐Feel alone/trouble making friends
- ☐Trouble controlling impulses
- ☐Difficulty with loss or death
- ☐Withdrawn
- ☐Clingy/tearful
- ☐Client seems to see/hear/smell/feel/taste things that aren't really there
- ☐Client has thoughts or beliefs that are false or irrational
- ☐Verbally or physically aggressive
- ☐Worry that client is suicidal
- ☐Worry that client wants to harm others
- ☐Self-harming behaviors
- ☐Client behavior is out of control
- ☐Dramatic mood swings
- ☐Client is excessively irritable
- ☐Obsessions/compulsions
- ☐Abuse (physical/sexual/emotional/verbal)
- ☐Trauma other than abuse (natural disaster, accident, crime witness, etc.)
- ☐Trouble concentrating
- ☐Trouble staying organized
- ☐Refusing to attend school
- ☐Getting in trouble at school
- ☐Trouble following directions
- ☐Learning/memory problems
- ☐Excessive interest in violent themes
- ☐Trouble getting child to bed at night
- ☐Client wakes up often/has trouble sleeping
- ☐Nightmares
- ☐Other: _____

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7. Regarding the **most important** reason you are seeking services for the client, 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 the client's functioning?
☐Client can do all the things client needs and wants to do
☐Client struggles a bit but is able to do all client needs and wants to do
☐ Client can only do some of the things client needs and wants to do
☐Client can barely do the things client needs to do
☐Client is unable to take care of self

8. Please describe relationship/attachment dynamics (strengths and concerns) with significant caregivers and siblings:
_____
_____
_____
_____
_____

9. Please describe any major/minor/ongoing traumatic experiences affecting the client or close family members:
_____
_____
_____
_____
_____

10.Please describe other stressors affecting family functioning (ie: marital issues, co-parenting issues, financial strain, school issues):
_____
_____
_____
_____
_____

11. Please describe any anticipated barriers toward treatment progress (ie: What might make therapy difficult for the client/family?):
_____
_____
_____
_____
_____

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12. Please describe any anticipated strengths toward treatment progress. (ie: Why do you feel the client/family will do well in therapy?):
_____
_____
_____
_____
_____

13. Has there been a recent assessment/consultation with a psychiatrist, psychologist, neuropsych, etc. to clarify diagnosis/treatment?

☐Yes ☐No If yes, date of consultation _____ and by whom _____.