# Outpatient Therapy Questionnaire (Ages 14 to 18)

Clear Harbor Counseling

**Identifying Information:**

**Child's Name**: _____ **Sex**:_____ **Today's Date**: _____

**Date of Birth**:_____ **Age:** _____ **Racial/Ethnic Background**: _____

**Form Completed By**: _____ **Relation:** _____

**Parents:**

| | Name | Age | Occupation |
|---|---|---|---|
| Parent | | | |
| Parent | | | |
| Step-Parent | | | |
| Step-Parent | | | |

Parents Marital Status:_____ Married _____Widowed _____ Divorced _____ Single_____ Partnered

Who has legal custody?

_____

If shared physical custody, what is the arrangement:

_____

**Living Situation:**

Own Home ☐ Renting ☐ Shelter ☐ Homeless ☐ With Others in Their Home ☐

**Others living in the house with your child:**

| Name | Age | Relationship | Occupation/Grade | Quality of Relationship |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Pets: _____

_____

Revised 07/21

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**Reason for Referral:**

Who referred you for services?

_____

_____

What has happened/is going on that caused you to seek services? What is the main issue/concern?

_____

_____

_____

_____

_____

_____

What are your goals for therapy? What do you hope will change? What would be helpful to you?

_____

_____

_____

_____

What other help have you sought recently?

_____

_____

**Sleep**

| Check all that apply | | Describe | Frequency | How long has it been happening? |
|---|---|---|---|---|
| | Problems falling asleep | | | |
| | Problems staying asleep | | | |
| | Sleeping too much | | | |
| | Sleeping too little | | | |
| | Waking too early | | | |
| | Nightmares | | | |
| | Other sleep issues | | | |

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**Eating**

| Check all that apply | | Describe | Frequency | How long has it been happening? |
|---|---|---|---|---|
| | Eating concerns | | | |
| | Made comments about needing to lose weight or being fat | | | |
| | Purges | | | |
| | Is dieting | | | |
| | Appetite changes | | | |
| | Weight changes | | | |

**Mood**

| Check all that apply | | Describe | Frequency | How long has it been happening? |
|---|---|---|---|---|
| | Lacks interest in activities they used to enjoy | | | |
| | Changed level of activity | | | |
| | Changed groups of friends | | | |
| | Socially withdrawn | | | |
| | Fatigue | | | |
| | Tearfulness | | | |
| | Sadness | | | |
| | Depression | | | |
| | Morbid Thoughts (talking about death) | | | |
| | Suicidal Threats | | | |
| | Suicidal Intent/Plans | | | |
| | Self-Harming Behavior (cutting, erasing self, punching walls, etc) | | | |
| | Mood swings | | | |
| | Easily Irritated | | | |

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**Behavior and Attention**

| Check all that apply | | Describe | Frequency | How long has it been happening? |
|---|---|---|---|---|
| | Concentration Problems | | | |
| | Having too much energy/cannot sit still | | | |
| | Focus too much (in their own world) | | | |
| | Completes tasks carelessly | | | |
| | Distracts/Annoys others | | | |
| | Bullies others | | | |
| | Is bullied | | | |
| | Disorganized/Forgetful | | | |
| | Has difficulty following directions | | | |
| | Aggressive behavior | | | |
| | Lies/ /does not tell the truth | | | |
| | Takes things that do not belong to them | | | |
| | Running away | | | |
| | Impulse control | | | |
| | Mean to animals | | | |
| | Gets stuck or obsesses on certain things | | | |
| | Plays with fire/matches | | | |
| | Destroys own/others' possessions | | | |

**Anxiety**

| Check all that apply | | Describe | Frequency | How long has it been happening? |
|---|---|---|---|---|
| | Worry/Anxiety | | | |
| | Fearfulness | | | |
| | Excessive shyness | | | |
| | Social Fear | | | |
| | Withdrawn | | | |
| | Unassertive | | | |

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| | | | | |
|---|---|---|---|---|
| | Stomach aches headaches/pain | | | |
| | Flashbacks/intrusive thoughts | | | |
| | School Refusal | | | |
| | Hypervigilance | | | |
| | Startles Easily | | | |
| | Compulsive Behavior | | | |

**Other Symptoms**

| **Check all that apply** | | **Describe** | **Frequency** | **How long has it been happening?** |
|---|---|---|---|---|
| | Personality Change | | | |
| | Peer/social Problems | | | |
| | Seeing, feeling, tasting, smelling or hearing things that are not there | | | |
| | Unusual/bizarre ideas | | | |
| | Hygiene problems | | | |

**Any other symptoms or issues that you think would be helpful for us to know about?**

_____

_____

_____

_____

**Childhood Life Events:**

Below is a list of events that may occur in a child's life. Please check any events that you know or suspect your child to have experienced.

| X if Yes | Age | Event | Other Information |
|---|---|---|---|
| | | Major Natural Disaster (flood, tornado) | |
| | | House Fire | |
| | | Serious Car Accident | |
| | | Physical Abuse | |
| | | Periods of Time When Adults were Unable to Care for them | |

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| | | | |
|---|---|---|---|
| | | Emotional abuse | |
| | | Impaired Parenting (due to parental mental health issues, substance use, etc) | |
| | | Exposure to Domestic Violence | |
| | | Exposure to Adult Substance Use | |
| | | Multiple Separations from Caregiver (military deployments, working away from home) | |
| | | Frequent Moves | |
| | | Homelessness | |
| | | Sexual Abuse | |
| | | Bullying | |
| | | Unexpected Death of a Close Relative | |
| | | Major Medical Procedure or Surgeries | |
| | | Any Other Scary or Dangerous Event | |

**Substance Use History:**

No Yes

___ _____ To your knowledge, does your child drink?

If yes, when did they start and how often do they drink?

_____

_____ _____ To your knowledge, does your child smoke cigarettes?

If yes, when did they start and how often do they smoke?

_____

___ _____ To your knowledge, does your child use drugs?

What have they used? _____

When did they start and how often do they use:? _____

Has your child ever attended chemical dependency treatment?

Where: _____

When:_____

# Outpatient Therapy Questionnaire (Ages 14 to 18)


**Medical History:**

Primary Care Physician: _____
Location:_____

Date of Last Well Child Visit:
_____

Date of Last Dental Visit:
_____

If your child is female, age of onset of menstruation? _____

Has your child had any prior surgeries? _____No _____Yes (what and when)

Has your child been hospitalized for any reason? _____No _____ Yes (for what and when)

Current Medications (dosage):
_____

Past Medications:
_____

Allergies: _____

**Family History:**
Are there any relatives of the child (including parents, grandparents, aunts, uncles or cousins) who have any of the following conditions?

| | **Relationship** | | **Relationship** |
|---|---|---|---|
| ADHD | | Autism/Asperger's | |
| Alcohol/Drug Problems | | Anxiety/OCD | |
| Brain Injury | | Bipolar Disorder | |
| Depression | | Developmental Delays | |
| Domestic Violence | | Eating Disorder | |
| Learning Disorders | | Mental Health Hospitalizations | |
| Physical Abuse | | PTSD | |
| Schizophrenia | | School Problems | |
| Sexual Abuse | | Suicide Attempts | |

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Who are the other important people in your child's life?( i.e. relatives, mentors, coaches, family friends, etc)

_____

_____

How does your child get along with your extended family or adult friends?

_____

_____

_____

**Developmental History:**

Where was your child born?_____

What was your reaction to finding out that you were pregnant with your child?

What was your relationship status when you found out you were pregnant?

What was the pregnancy with your child like?

Was your child exposed to any substances during pregnancy or prior to learning you were pregnant?
_____drugs (prescribed or street drugs),
_____tobacco, or
_____ alcohol during pregnancy?

Did you have any medical issues or sources of extreme stress during pregnancy?

_____

_____

Describe the delivery:
_____Vaginal
_____C-section
_____Uncomplicated
_____Premature (how early?) _____
_____Late (how late) _____
_____Complicated (describe) _____

Did you or the child stay in the hospital for an extended period of time?
_____Yes
_____No (describe) _____

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Describe any challenges during infancy (i.e. maternal depression, financial stress, frequent moves).

_____

_____

Describe what your child was like to care for as an infant (i.e. easy, difficult, enjoyable, colicky, fussy)

_____

_____

Were developmental milestones (talking, walking etc) delayed or met on time?

_____

_____

**School:** What grade is your child in? _____

Does your child have learning, social or behavior problems at school?
_____No
_____Yes (describe)

Does/has your child receive any special educational services (IEP, 504, Title 1) or have special educational needs?
_____No
_____Yes (describe)

**Social History**

Does your child have a positive group of friends?

_____

_____

Is your child dating?

Is your child sexually active?

Has your child ever had any prior social service involvement?
_____No
_____Yes (when) _____(social worker's name)
_____

Has the child been in foster placement?
_____ No
_____ Yes (when and why)_____

_____

# Outpatient Therapy Questionnaire (Ages 14 to 18)

Has your child ever been in trouble with the law? ____No _____Yes

If yes, when and what for?_____

Is there a current probation agent?_____

**Cultural Issues:**

Does your family participate in any faith, religious or spiritual practices?

____No

____if Yes, Describe:

_____

_____

Are there other things that you would like to share?

_____

_____

_____

_____

What are your child's strengths and interests?

_____

_____

_____

_____

_____

_____