

# Insight Psychotherapy Group

A Professional Corporation

## Caregiver Intake Questionnaire

Please complete the following information about your child to the best of your ability. Your child's therapist will go over this information with you when you meet to help clarify your answers.

Name of person completing this form: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Name of child: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Is this child in foster care?  No  Yes Reason for care: \_\_\_\_\_ How long? \_\_\_\_\_

Parent's marital status:  Married  Separated  Divorced  Widowed  Never married

If parents are divorced, who has legal custody?  Mother  Father  Shared  Other \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Maiden: \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Ph(h): \_\_\_\_\_ (w): \_\_\_\_\_

Father's Name: \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Ph(h): \_\_\_\_\_ (w): \_\_\_\_\_

### 1. PRESENTING PROBLEM

What is the main problem you are seeking help for? \_\_\_\_\_

Does your child show any of the following behaviors or problems?

Problems with reading	<input type="checkbox"/> No <input type="checkbox"/> Yes (315.00)	Defiant	<input type="checkbox"/> No <input type="checkbox"/> Yes (313.81)
Problems with math	<input type="checkbox"/> No <input type="checkbox"/> Yes (315.1)	Blames others	<input type="checkbox"/> No <input type="checkbox"/> Yes (313.81)
Problems with writing skills	<input type="checkbox"/> No <input type="checkbox"/> Yes (315.2)	Problems with eating	<input type="checkbox"/> No <input type="checkbox"/> Yes (307.xx)
Problems with body coordination	<input type="checkbox"/> No <input type="checkbox"/> Yes (315.4)	Tics	<input type="checkbox"/> No <input type="checkbox"/> Yes (307.xx)
Problems with self expression	<input type="checkbox"/> No <input type="checkbox"/> Yes (315.31)	Unable to control bowels	<input type="checkbox"/> No <input type="checkbox"/> Yes (787.6)
Problems with understanding others	<input type="checkbox"/> No <input type="checkbox"/> Yes (315.32)	Wets bed the bed	<input type="checkbox"/> No <input type="checkbox"/> Yes (307.6)
Problems with speech	<input type="checkbox"/> No <input type="checkbox"/> Yes (315.39)	Has trouble being alone	<input type="checkbox"/> No <input type="checkbox"/> Yes (309.21)
Stuttering	<input type="checkbox"/> No <input type="checkbox"/> Yes (307.0)	Trouble being away from home	<input type="checkbox"/> No <input type="checkbox"/> Yes (309.21)
Inattentive	<input type="checkbox"/> No <input type="checkbox"/> Yes (314.xx)	Refuses to talk at times	<input type="checkbox"/> No <input type="checkbox"/> Yes (313.23)
Hyperactive	<input type="checkbox"/> No <input type="checkbox"/> Yes (314.xx)	Problems expressing affection	<input type="checkbox"/> No <input type="checkbox"/> Yes (313.89)
Aggressive toward others	<input type="checkbox"/> No <input type="checkbox"/> Yes (312.xx)	Using drugs or alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes (30x.xx)
Destroys property	<input type="checkbox"/> No <input type="checkbox"/> Yes (312.xx)	Appears depressed	<input type="checkbox"/> No <input type="checkbox"/> Yes (300.x)
Stealing	<input type="checkbox"/> No <input type="checkbox"/> Yes (312.xx)	Mood changes easily	<input type="checkbox"/> No <input type="checkbox"/> Yes (296.xx)
Lying	<input type="checkbox"/> No <input type="checkbox"/> Yes (312.xx)	Appears anxious or fearful	<input type="checkbox"/> No <input type="checkbox"/> Yes (300.xx)
Tries to break rules	<input type="checkbox"/> No <input type="checkbox"/> Yes (312.xx)	Obsesses about things	<input type="checkbox"/> No <input type="checkbox"/> Yes (300.3)
Loses temper easily	<input type="checkbox"/> No <input type="checkbox"/> Yes (313.81)	Wants to be the opposite sex	<input type="checkbox"/> No <input type="checkbox"/> Yes (302.xx)
Argues a lot	<input type="checkbox"/> No <input type="checkbox"/> Yes (313.81)	Problems with sleep	<input type="checkbox"/> No <input type="checkbox"/> Yes (307.xx)

## 2. MENTAL HEALTH HISTORY

Has your child ever seen a psychiatrist or therapist?  No  Yes For what condition? \_\_\_\_\_  
When? \_\_\_\_\_ With whom? \_\_\_\_\_

Has your child ever been diagnosed with any of the following disorders? If Yes, what year? \_\_\_\_\_

Attention Deficit Hyperactivity Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	Speech and Language Delays	<input type="checkbox"/> No <input type="checkbox"/> Yes
Learning Disability	<input type="checkbox"/> No <input type="checkbox"/> Yes	Autism	<input type="checkbox"/> No <input type="checkbox"/> Yes
Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes	Pervasive Developmental Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes

Has your child ever attempted suicide?  No  Yes When? \_\_\_\_\_

Has your child ever been on medications prescribed by a psychiatrist?  No  Yes

Name of medication: \_\_\_\_\_ When? \_\_\_\_\_ Any negative reactions?  No  Yes \_\_\_\_\_

Name of medication: \_\_\_\_\_ When? \_\_\_\_\_ Any negative reactions?  No  Yes \_\_\_\_\_

Name of medication: \_\_\_\_\_ When? \_\_\_\_\_ Any negative reactions?  No  Yes \_\_\_\_\_

Has your child ever had psychological testing  No  Yes Year \_\_\_\_\_ With whom? \_\_\_\_\_

For what reason? \_\_\_\_\_ Which tests (if known)? \_\_\_\_\_

## 3. FAMILY HISTORY

Has anyone in your family had the following mental health conditions?

Drug Abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes	Suicide	<input type="checkbox"/> No <input type="checkbox"/> Yes	Attention Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Alcohol Abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes	Psychiatric Hospitalizations	<input type="checkbox"/> No <input type="checkbox"/> Yes	Learning problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes	Psychiatric Medications	<input type="checkbox"/> No <input type="checkbox"/> Yes	Manic Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes
Suicide Attempts	<input type="checkbox"/> No <input type="checkbox"/> Yes	Therapy or Counseling	<input type="checkbox"/> No <input type="checkbox"/> Yes	Schizophrenia	<input type="checkbox"/> No <input type="checkbox"/> Yes

Names, ages and gender of child's siblings

Name	Age	Gender	Relationship	Name	Age	Gender	Relationship
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step

Is your child adopted?  No  Yes At what age? \_\_\_\_\_

## 4. DEVELOPMENTAL HISTORY

During the mother's pregnancy did any of the following occur?

Inadequate prenatal care	<input type="checkbox"/> No <input type="checkbox"/> Yes	Mother had emotional problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mother smoked	<input type="checkbox"/> No <input type="checkbox"/> Yes	Father used drugs or alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mother used caffeine	<input type="checkbox"/> No <input type="checkbox"/> Yes	Mother was victim of violence	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mother used drugs or alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes	Mother had medical problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mother using medications	<input type="checkbox"/> No <input type="checkbox"/> Yes	Mother was hospitalized	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mother had accident/injury	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other	

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During your child's birth did any of the following problems or conditions occur?

Child was premature	<input type="checkbox"/> No <input type="checkbox"/> Yes	Delayed crying	<input type="checkbox"/> No <input type="checkbox"/> Yes
Complicated labor	<input type="checkbox"/> No <input type="checkbox"/> Yes	Baby given oxygen or transfusion	<input type="checkbox"/> No <input type="checkbox"/> Yes
Breech, caesarian or forceps delivery	<input type="checkbox"/> No <input type="checkbox"/> Yes	Baby placed in incubator	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fetal distress	<input type="checkbox"/> No <input type="checkbox"/> Yes	Baby remained in hospital after mother went home	<input type="checkbox"/> No <input type="checkbox"/> Yes

Were there any special problems, delays or events regarding your child's...

Holding head up	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bowel or bladder training	<input type="checkbox"/> No <input type="checkbox"/> Yes
Learning to bond	<input type="checkbox"/> No <input type="checkbox"/> Yes	Feeding self with a spoon	<input type="checkbox"/> No <input type="checkbox"/> Yes
Learning to sit-up alone	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tying shoes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Learning to crawl	<input type="checkbox"/> No <input type="checkbox"/> Yes	Dressing independently	<input type="checkbox"/> No <input type="checkbox"/> Yes
Sleeping through the night	<input type="checkbox"/> No <input type="checkbox"/> Yes	Writing his or her name	<input type="checkbox"/> No <input type="checkbox"/> Yes
Learning to walk	<input type="checkbox"/> No <input type="checkbox"/> Yes	Ability to make or get along with friends	<input type="checkbox"/> No <input type="checkbox"/> Yes
Learning to talk	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other	

Has your child ever been physically abused?  No  Yes When? \_\_\_\_\_

Has your child ever been neglected?  No  Yes When? \_\_\_\_\_

Has your child ever been sexually abused or molested?  No  Yes When? \_\_\_\_\_

Has your child ever witnessed violent acts?  No  Yes When? \_\_\_\_\_

Have there been any other events in your child's life, which you consider to have been traumatic?  No  Yes

## 5. SCHOOL HISTORY

Your child's current grade level:  Preschool  K  1  2  3  4  5  6  7  8  9  10  11  12

Has your child ever had...

Problems learning certain subjects?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Disruptive class behavior?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Problems with paying attention?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Suspensions or transfers?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Problems getting along with teachers?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Special education?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Problems with studying?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Special day classes?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Problems with grades?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tutoring?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Problems with truancy?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other	

## 6. OTHER HISTORY

Has your child ever...

Been in trouble with the law?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Used any weapons?	<input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes
Had anyone close to them die?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Experimented with sex?	<input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes
Been removed from the family?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Been sexually active?	<input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes
Been in foster care?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Been on birth control?	<input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes
Been involved in a gang?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Used drugs or alcohol?	<input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes

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## 7. MEDICAL HISTORY

Does your child have any allergies?  No  Yes Allergic to: \_\_\_\_\_

Is your child currently being treated for any medical condition?  No  Yes Condition: \_\_\_\_\_

Name of your child's pediatrician/physician: \_\_\_\_\_ City: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

Name of your child's dentist: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

Is your child on medications for any medical condition?  No  Yes

Name of medication: \_\_\_\_\_ For what condition? \_\_\_\_\_

Name of medication: \_\_\_\_\_ For what condition? \_\_\_\_\_

Name of medication: \_\_\_\_\_ For what condition? \_\_\_\_\_

Has your child ever been hospitalized?  No  Yes For what condition? \_\_\_\_\_

Has your child had any of the following communicable diseases?

Chicken pox	<input type="checkbox"/> No <input type="checkbox"/> Yes	Polio	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rubella	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mumps	<input type="checkbox"/> No <input type="checkbox"/> Yes	Measles	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rheumatic Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	Parasites	<input type="checkbox"/> No <input type="checkbox"/> Yes
Meningitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other:			

Has your child had any of the following immunizations

Polio	<input type="checkbox"/> No <input type="checkbox"/> Yes	Measles	<input type="checkbox"/> No <input type="checkbox"/> Yes	HBV (Hepatitis B)	<input type="checkbox"/> No <input type="checkbox"/> Yes
DTP	<input type="checkbox"/> No <input type="checkbox"/> Yes	MMR (Measles, Mumps, Rubella)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other	

Has your child had any of the following medical conditions?

Birth Defects	<input type="checkbox"/> No <input type="checkbox"/> Yes	Eating Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Yes
Stomach Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dizziness or Fainting	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bedwetting	<input type="checkbox"/> No <input type="checkbox"/> Yes
Head Injury	<input type="checkbox"/> No <input type="checkbox"/> Yes	Soiling	<input type="checkbox"/> No <input type="checkbox"/> Yes
Asthma, Hay Fever, Hives, Rash	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sleep Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Surgeries/Serious Illnesses/Accidents	<input type="checkbox"/> No <input type="checkbox"/> Yes	Speech Therapy	<input type="checkbox"/> No <input type="checkbox"/> Yes
Epilepsy, Convulsions, Seizures	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Frequent or Severe Headache	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes
Back, Muscle or Joint Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	Vision Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hepatitis, Jaundice or Liver Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other	

Signature \_\_\_\_\_ Date: \_\_\_\_\_