CAREGIVER INTAKE QUESTIONNAIRE

Please complete the following information to the best of your ability. The client's therapist will review and clarify your responses.

Name of person completing this form:	Relationship to client:
Name of client:	DOB:
Is this client in foster care: ☐No ☐Yes ☐In past	Reason for care:_____ How long and when if past: _____
Parent's marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never married	
If client's parents are divorced, who has **legal** custody: ☐ Mother ☐ Father ☐ Shared ☐ Other	

Mother's name:	Maiden:	Home address:
Phone (home/mobile):	Phone (work):	
Father's name:		Home address:
Phone (home/mobile):	Phone (work):	

1. CLIENT PRESENTING PROBLEM

Briefly describe the main problem for which you are seeking help for this client:

2. CLIENT MENTAL HEALTH HISTORY

Has this client ever seen a psychiatrist or therapist: ☐No ☐Yes

For what condition/s or diagnosis/es: _____

Provide the date of service(s) and contact information for the health professional(s):

Has this client ever engaged in any of the following:

Had thoughts (verbal, written, etc.) of killing or hurting him/herself: ☐No ☐Yes Date(s):_____

Attempted suicide: ☐No ☐Yes Date(s): _____ Method(s):_____

Intentionally **injured/harmed him/herself:** ☐No ☐Yes Date(s): _____ Method(s):_____

Answer the following about this client:

Has problems with self-expression: ☐No ☐Yes

Refuses to talk at times: ☐No ☐Yes

Obsesses about things: ☐No ☐Yes

Does not identify with sex assigned at birth: ☐No ☐Yes

Has this client ever been on psychiatric medication prescribed by a health professional: ☐No ☐Yes

Name of medication:	Dates:	Negative reactions: ☐No ☐Yes: _____
Name of medication:	Dates:	Negative reactions: ☐No ☐Yes: _____
Name of medication:	Dates:	Negative reactions: ☐No ☐Yes: _____

Has this client ever had psychological testing: ☐No ☐Yes

What was the reason for testing:

Provide the date and location where the evaluation was conducted:

✓ Provide a list of the test names administered to this client (if known) and/or *bring a copy of the psychological testing report to your next appointment*. _____

_____

3. FAMILY BACKGROUND INFORMATION

Provide information on the client's siblings including name, age, and gender:

Name	Age	Gender	Relationship	Name	Age	Gender	Relationship
		☐M ☐F	☐Full ☐Half ☐Step			☐M ☐F	☐Full ☐Half ☐Step
		☐M ☐F	☐Full ☐Half ☐Step			☐M ☐F	☐Full ☐Half ☐Step
		☐M ☐F	☐Full ☐Half ☐Step			☐M ☐F	☐Full ☐Half ☐Step
		☐M ☐F	☐Full ☐Half ☐Step			☐M ☐F	☐Full ☐Half ☐Step

Is this client adopted: ☐No ☐Yes If yes, at what age: _____

Complete the following information regarding **family mental health** conditions and treatment:

Drug Abuse	☐No ☐Yes	Suicide	☐No ☐Yes	Attention Problems	☐No ☐Yes
Alcohol Abuse	☐No ☐Yes	Suicide Attempts	☐No ☐Yes	Learning Problems	☐No ☐Yes
Depression	☐No ☐Yes	Manic Depression	☐No ☐Yes	Schizophrenia	☐No ☐Yes
Psychiatric Hospitalizations	☐No ☐Yes	Psychiatric medications	☐No ☐Yes	Mental health therapy/counseling	☐No ☐Yes

4. CLIENT DEVELOPMENTAL HISTORY

Complete the following information regarding the **biological mother's pregnancy:**

Inadequate prenatal care	☐No ☐Yes	Mother had emotional problems	☐No ☐Yes
Mother smoked	☐No ☐Yes	Mother was exposed to second-hand smoke	☐No ☐Yes
Mother consumed caffeine	☐No ☐Yes	Mother was a victim of violence	☐No ☐Yes
Mother used drugs/alcohol	☐No ☐Yes	Mother had medical problems	☐No ☐Yes
Mother used medications	☐No ☐Yes	Mother was hospitalized	☐No ☐Yes
Mother had accident/injury	☐No ☐Yes	Other: _____(specify)	☐No ☐Yes

Complete the following information regarding the **client's birth:**

Client was premature	☐No ☐Yes	Delayed crying	☐No ☐Yes
Complicated labor	☐No ☐Yes	Baby given oxygen or transfusion	☐No ☐Yes
Breech, caesarian or forceps delivery	☐No ☐Yes	Baby placed in incubator	☐No ☐Yes
Fetal distress	☐No ☐Yes	Baby remained in hospital after mother went home	☐No ☐Yes

Indicate whether the client experienced any **delays/problems with the following developmental/behavioral milestones:**

Holding head up	☐No ☐Yes	Bowel or bladder training	☐No ☐Yes
Learning to bond	☐No ☐Yes	Feeding self with a spoon	☐No ☐Yes
Learning to sit up alone	☐No ☐Yes	Tying shoes	☐No ☐Yes
Learning to crawl	☐No ☐Yes	Dressing independently	☐No ☐Yes
Sleeping through the night	☐No ☐Yes	Writing his or her name	☐No ☐Yes
Learning to walk	☐No ☐Yes	Ability to make or get along with friends	☐No ☐Yes
Learning to talk	☐No ☐Yes	Other: _____(specify)	☐No ☐Yes

Indicate whether the client has ever experienced any of the following:

Physical abuse	☐No ☐Yes	When: _____
Neglect (e.g., lack of food, shelter, clothing)	☐No ☐Yes	When: _____
Sexual abuse or molestation	☐No ☐Yes	When: _____
Emotional abuse	☐No ☐Yes	When: _____
Witness of domestic violence	☐No ☐Yes	When: _____

5. CLIENT SCHOOL HISTORY

What is this client's current grade level: ☐Preschool ☐K ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12

Indicate whether this client has ever received and/or currently receives any of the following **support services at school:**

Occupational Therapy	☐No ☐Yes	Grade(s): _____
Physical Therapy	☐No ☐Yes	Grade(s): _____
Speech Therapy	☐No ☐Yes	Grade(s): _____
Resource room	☐No ☐Yes	Grade(s): _____
Counseling	☐No ☐Yes	Grade(s): _____
Tutoring	☐No ☐Yes	Grade(s): _____
Testing accommodations	☐No ☐Yes	Grade(s): _____
1:1 education (e.g., from a teacher's aide)	☐No ☐Yes	Grade(s): _____
Other: _____(specify)	☐No ☐Yes	Grade(s): _____

✓ Does this client have an Individualized Education Plan (IEP) or 504 Plan:
☐No ☐Yes. *If yes, please bring to your next visit.*

6. CLIENT HIGH RISK BEHAVIORS

Indicate whether the client has ever engaged in any of the following high risk behaviors:

Gangs	☐No ☐Yes	Sexting	☐No ☐Yes
Use of weapons	☐No ☐Yes	Dangerous driving	☐No ☐Yes
Un/protected sexual activity	☐No ☐Yes	Other: _____(specify)	☐No ☐Yes

7. CLIENT MEDICAL HISTORY

Name of client's *pediatrician/physician*:	City:
Pediatrician office phone:	Date of last physical exam:
Does the client have a *dentist* s/he visits regularly: ☐No ☐Yes	Date of the last dental exam:

Has this client had any of the following **medical conditions:**

Birth defects	☐No ☐Yes	Eating problems/difficulties	☐No ☐Yes
High blood pressure	☐No ☐Yes	Pregnancy	☐No ☐Yes
Stomach problems	☐No ☐Yes	Kidney trouble	☐No ☐Yes
Dizziness or fainting	☐No ☐Yes	Diabetes	☐No ☐Yes
Head injury	☐No ☐Yes	Hearing impairment	☐No ☐Yes
Asthma, hay fever, hives, rash	☐No ☐Yes	Vision impairment	☐No ☐Yes
Allergies: _____(specify)	☐No ☐Yes	Back, muscle, or joint problems	☐No ☐Yes
Surgeries/serious illness/accidents	☐No ☐Yes	Hepatitis, jaundice, or liver problems	☐No ☐Yes
Epilepsy, convulsions, seizures	☐No ☐Yes	Body coordination/balance problems	☐No ☐Yes
Frequent or severe headaches	☐No ☐Yes	Other: _____(specify)	☐No ☐Yes

Is this client currently on **medications for any medical condition** listed above: ☐No ☐Yes

Name of medication:	Condition for which client is taking this medication:
1)	
2)	
3)	

Has this client ever been **hospitalized:** ☐No ☐Yes. If so, what was the reason: _____
Are this client's **immunizations/vaccines** up-to-date: ☐No ☐Yes

Has this client had any of the following **communicable diseases:**

Chicken pox	☐No ☐Yes	Polio	☐No ☐Yes	Rubella	☐No ☐Yes	Meningitis	☐No ☐Yes
Mumps	☐No ☐Yes	Measles	☐No ☐Yes	Hepatitis	☐No ☐Yes	Other: _____	☐No ☐Yes
Tuberculosis	☐No ☐Yes	Parasites	☐No ☐Yes	Rheumatic Fever	☐No ☐Yes		

Thank you for completing this form.
Use the back side of this sheet to share any additional relevant information regarding this client.