Insight Psychological Services

5212 E. 69th Place
Tulsa, Oklahoma 74136

Date_____

Child's Name_____ Date of Birth (DOB) _____ Age _____
Name of Insurance Provider_____ Soonercare/Medicaid #_____
Address _____ City _____ State _____ Zip _____
School _____ Grade _____
Child's Sex: ☐ Male ☐ Female
Child's Ethnicity: ☐ Caucasian/White ☐ African-American ☐ Hispanic ☐ Native American
☐ Asian/Pac. Islander ☐ Other_____

PARENTS/GUARDIANS

_____
Name of person completing this form Relationship to child

_____ _____
Mother's name, DOB Father's name, DOB

_____ _____
Mother's spouse (if applicable) Father's spouse (if applicable)

_____ _____
Mother's Address (if different from child's) Father's Address (if different from child's)

_____ _____
Home Tel # Cell # Home Tel # Cell #

_____ _____
Employer Work # Employer Work #

_____ _____
Legal Guardian's name (if different from above) Emergency Contact (not parent/guardian)

_____ _____
Home/cell # Work # Home/cell # Work #

_____
Child's Pediatrician Phone #

_____
Address City State Zip

Others in the home: (Name, Age, and Relationship to child)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Immediate family living outside the home: (such as biological parent, brothers, sisters)

_____ _____

_____ _____

REFERRAL HISTORY

1. Who referred you and what are the primary concerns?

_____

_____

2. Describe the problems that are affecting your child and family.

_____

_____

_____

_____

3. When did you first become aware of these problems?

_____

_____

4. What seems to help the problems?

_____

_____

5. Has your child ever been seen by a psychologist, psychiatrist, counselor, or therapist? ☐ Yes ☐ No
If yes, please describe why, when, and from whom:

_____

_____

6. Please list any mental health diagnosis your child has been given:

_____

_____

7. Explain type of discipline strategy you use with the child:

_____

_____

SOCIAL HISTORY

1. Does your child have friends in the neighborhood? ☐ Yes ☐ No At school? ☐ Yes ☐ No
2. Does your child have the opportunity to play with same-age children? ☐ Yes ☐ No
3. Is your child involved in extracurricular or group/club activities? ☐ Yes ☐ No

Please list:

_____

Insight Psychological Services
T: 918-280-0101 F: 844-752-8249

4. Is your child involved in community support or self-help groups? (Big Brothers/Sisters, Jewish Community Center, Ala-non, etc.)

_____

5. What are the child's hobbies?

_____

_____

6. Please describe any concerns you have with your child's social skills or social life:

_____

_____

PROBLEM AREAS: Please check any problems your child is experiencing.

☐ Pain issues
☐ Overeats/Under eats/Picky Eater (circle all that apply)
☐ Difficulty with daily living skills (dressing, showering, feeding)
☐ Poor family relationships
☐ Seeing or hearing things others don't see or hear (hallucinations)
☐ Untrue or odd thoughts and/or beliefs (delusions)
☐ Depressed mood
☐ Elevated mood/Overly excited for no reason
☐ Mood swings/Emotional outbursts
☐ Disobedient/Defiant
☐ Loss of significant person/Bereavement
☐ Inattention/Easily distracted
☐ Difficulty making or maintaining friendships
☐ Temper tantrums/Aggressive behavior
☐ Problems going to bed/Staying asleep/Waking up (circle which)
☐ Reduced energy
☐ Low self-esteem
☐ Thoughts of suicide
☐ Self-injury (type:_____)
☐ Repetitive behavior
☐ Impulsive behavior
☐ Phobias or excessive fears
☐ Nightmares
☐ Shy or avoidant of others
☐ Difficulty concentrating
☐ Argumentative
☐ Violent/Destructive behavior
☐ Parents' divorced
☐ Anxious/Worried/Nervous
☐ Sexual problems
☐ Restless/Unable to sit still

Additional problems not noted above/Additional explanation of problems above:

_____

_____

_____

_____

_____

_____

_____

_____

Insight Psychological Services
T: 918-280-0101 F: 844-752-8249

ABUSE/TRAUMA HISTORY: Has your child ever been abused, experienced a traumatic event, or caused harm to another? ☐ Yes ☐ No If Yes, check all that apply IF No, SKIP THIS SECTION.

☐ Victim of emotional abuse
☐ Victim of verbal abuse
☐ Victim of physical abuse
☐ Victim of physical neglect
☐ Victim of domestic violence/abuse
☐ Victim of sexual abuse/molestation
☐ Witnessed or experienced community violence
☐ Physically harmed another person
☐ Sexually abused or molested another person
☐ Harmed an elderly/older person
☐ Purposely cut or burned her/himself
☐ Been cruel to animals
☐ Experienced a traumatic event (e.g. witnessed violence, etc.)

Provide additional information for any "Yes" answers:

_____
_____
_____

BIRTH, DEVELOPMENT & HEALTH HISTORY:

Length of pregnancy (how many weeks/months?) Any complications during the pregnancy?

_____
_____

Child's birth weight _____ Length of labor _____

Mother's age when child was born _____Did you receive regular prenatal care? ☐ Yes ☐ No

Check box to describe mother's health during pregnancy:

☐ Medication Use ☐ Illness ☐ Serious injury
☐ Nicotine Use ☐ Alcohol Use ☐ Drug Use ☐ Other

Explain any checked boxes here:

_____
_____

Delivery by: ☐ Vaginal birth ☐ C-section

Provide information about any complications experienced during delivery (difficulty breathing, extended labor, etc…):

_____
_____
_____

DEVELOPMENTAL HISTORY: At what age did your child:

Crawl:_____ Begin to walk:_____ Toilet trained:_____
Begin to talk: _____ Use sentences:_____ Right or left handed:_____

Difficulties with separation from parent/caregiver: ☐ Yes ☐ No

Insight Psychological Services
T: 918-280-0101 F: 844-752-8249

Any areas in which your child seemed behind peers of the same age:

_____
_____
_____

Has your child received (past or present) any of the following services? At what age? Where?

Speech/language Therapy ☐ Yes ☐ No _____

Physical Therapy ☐ Yes ☐ No _____

Occupational Therapy ☐ Yes ☐ No _____

CHILD'S PHYSICAL HEALTH HISTORY:

Describe your child's physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please describe any current and/or past health problems:

_____
_____
_____

Is your child taking any medications (prescription, over the counter, herbal, supplements) on a regular basis? ☐ Yes ☐ No

List current medications here (type, amount, and times per day):

_____
_____
_____
_____
_____
_____

List past medications here (type, amount, and times per day):

_____
_____
_____
_____

FAMILY HISTORY & INFORMATION

Marital Status of Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Unmarried ☐ Widowed

If parents are divorced, who has legal custody? ☐ Mother ☐ Father ☐ Joint ☐ Other

If other, please specify: _____

If parents are separated or divorced, please describe physical custody and visitation arrangements:

_____
_____
_____

The child is: ☐ Biological ☐ Step-child ☐ Adopted ☐ Foster Child ☐ Other: _____

Insight Psychological Services
T: 918-280-0101 F: 844-752-8249

If an adopted or foster child, how long has the child been in your home? _____
Is the child aware that they are adopted or a foster child? ☐ Yes ☐ No

Provide as much information regarding biological parent(s) as possible if not legal guardians:
_____
_____
_____
_____

Please list any mental health diagnoses in the biological family:
(Examples: maternal grandfather – anxiety, mother – depression)
_____
_____
_____

AGENCY INVOLVEMENT

Has your child or family ever been involved with the following agencies? If yes, please explain below:
Child Protective Services (CPS) ☐ Yes ☐ No Caseworker/ phone # _____
Department of Human Services (DHS) ☐ Yes ☐ No Caseworker/ phone # _____
Court Appointed Advocate (CASA) or Guardian ad Litem (GAL) ☐ Yes ☐ No
Advocate/ phone # _____
Law Enforcement (Police) ☐ Yes ☐ No Probation/Juvenile Detention ☐ Yes ☐ No
Explanation from "Yes" answers above:
_____
_____
_____

SCHOOL HISTORY

Current school's name and address
_____

Age at Kindergarten entrance _____ Age at First Grade entrance_____

Has your child ever repeated a grade? ☐ Yes ☐ No If yes, what grade(s)? _____
Has your child has a frequent change of schools? ☐ Yes ☐ No If yes, how many schools? _____

Has your child ever completed intelligence, achievement or other testing through school? ☐ Yes ☐ No
If so, when was your child tested? _____
Does your child receive services through an Individual Education Plan (IEP) or 504 Plan? ☐ Yes ☐ No
If so, at what age/grade was the plan started?_____

Insight Psychological Services
T: 918-280-0101 F: 844-752-8249

Has your child ever been placed in a special education program? ☐ Yes ☐ No
If so, please mark the program type/classification: ☐ Cognitive Disability ☐ Emotional Disability
☐ Specific Learning Disability ☐ Multiple Disability ☐ Other Health Impairment ☐ Traumatic Brain Injury
☐ Hearing Impairment ☐ Visual Impairment ☐ Orthopedic Impairment ☐ Other _____

Learning Disabilities Tutoring ☐ Yes ☐ No _____
Special Communication Devices ☐ Yes ☐ No _____
Other services, please describe _____
Is your child involved in any vocational education? ☐ Yes ☐ No ☐ Not applicable
If yes, please describe: _____

Describe any areas in which your child is struggling academically
_____
_____

Does your child have difficulties at school in any of these areas? If so, please describe.
Problems with following rules or listening to teachers ☐ Yes ☐ No _____
Problems getting along with classmates ☐ Yes ☐ No _____
Behavioral problems/Outbursts ☐ Yes ☐ No _____
Emotional problems ☐ Yes ☐ No _____
Absenteeism or Truancy ☐ Yes ☐ No # of absences in the last 90 days _____
Not completing/turning in assignments ☐ Yes ☐ No_____
Suspensions/expulsions ☐ Yes ☐ No # of suspensions in the last 90 days _____
Other areas of concern _____
_____

EMPLOYMENT HISTORY

Has your child ever had a job? ☐ Yes ☐ No If yes, please complete the following information:
Name of employer _____ Job title _____
Employment skills/interests
_____
Problems/concerns
_____
Does your child receive SSDI? ☐ Yes ☐ No Does your child receive SSI? ☐ Yes ☐ No

Thank you for taking the time to complete our paperwork.

Insight Psychological Services
T: 918-280-0101 F: 844-752-8249