



## Background History and Current Strengths/Needs

Today's Date: \_\_\_\_\_

Name of Person(s)/ Completing Form: \_\_\_\_\_

Relationship(s) to Client \_\_\_\_\_

Why are you seeking treatment at this time? \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

### Personal Information:

Name of Client \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Child's phone \_\_\_\_\_

Email address that you check on a daily basis \_\_\_\_\_

Address \_\_\_\_\_

Child's School \_\_\_\_\_ District # \_\_\_\_\_ Grade \_\_\_\_\_

School's phone #: \_\_\_\_\_ Teacher(s) \_\_\_\_\_

Child lives with (father/mother/siblings/half-siblings/step-siblings/other). Please list names/dates of birth of any siblings \_\_\_\_\_

Is there a caregiver other than parents? Yes/No If yes, how often? \_\_\_\_\_

Any pets? Yes/No. Type of pet(s) and name(s): \_\_\_\_\_

### Insurance Coverage:

Subscriber's Name \_\_\_\_\_ Relation to Client \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

Subscriber's Address (if different from client) \_\_\_\_\_

None/self pay or Insurance Provider \_\_\_\_\_ PPO/HMO (circle)

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Copay Amount \_\_\_\_\_

Is there a secondary insurance policy? Yes/No. If so, secondary policy information \_\_\_\_\_

### Family Background

Parents' marital status \_\_\_\_\_ Date(s) \_\_\_\_\_

Who has legal custody of child? Mom(s)/Dad(s)/Both/Neither. Are there any custody considerations of which we should be aware? \_\_\_\_\_

Family's religious preference: \_\_\_\_\_ Church/synagogue attends \_\_\_\_\_

Is child adopted? Yes/No. If yes, where and at what age? \_\_\_\_\_

If child is adopted, what does child know about the adoption and/or birth family? \_\_\_\_\_

**Parent/Mother's name:** \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address (if different than client) \_\_\_\_\_

Education: \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Name/Location \_\_\_\_\_

Work Hours \_\_\_\_\_

Does parent travel for work? \_\_\_\_\_ How often? \_\_\_\_\_

**Parent/Father's name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Address (if different than client) \_\_\_\_\_

Education: \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Name/Location \_\_\_\_\_

Work hours \_\_\_\_\_

Does parent travel for work? \_\_\_\_\_ How often? \_\_\_\_\_

Have there been any recent family changes? Yes/No. Describe: \_\_\_\_\_

If yes, what was the child told about change(s) in the family? \_\_\_\_\_

How did the child react? \_\_\_\_\_

What activities does s/he enjoy doing? \_\_\_\_\_

Describe child's relationship with Mom/Parent \_\_\_\_\_

What are child's favorite activities to do with Mom/Parent? \_\_\_\_\_

Describe child's relationship with Dad/Parent \_\_\_\_\_

What are child's favorite activities to do with Dad/Parent? \_\_\_\_\_

Describe child's relationship with sibling(s) \_\_\_\_\_

What are child's favorite activities to do with sibling(s)? \_\_\_\_\_

How would you describe parents' relationship with each other? \_\_\_\_\_

Describe Mom/Parent's parenting style/approach with this child. \_\_\_\_\_

Describe Dad/Parent's parenting style/approach with this child. \_\_\_\_\_

Parents' current tobacco/alcohol/drug use: \_\_\_\_\_

**Pregnancy/Childbirth Background-If Adopted, Please Complete re: Birth Mom**

Please describe how mom felt during pregnancy, any medications prescribed, and their purpose \_\_\_\_\_

How much alcohol was consumed during pregnancy? \_\_\_\_\_

Any illicit drugs used during pregnancy? Yes/No. Name of drug(s)/how often used: \_\_\_\_\_

Please list any complications with conception, pregnancy, childbirth: \_\_\_\_\_

Was child born full term? \_\_\_\_\_ How many weeks gestation? \_\_\_\_\_ Vaginal/C-section \_\_\_\_\_

Weight at birth \_\_\_\_\_ Length at birth \_\_\_\_\_ Any concerns? \_\_\_\_\_

**Health Background**

Child's pediatrician \_\_\_\_\_ Phone \_\_\_\_\_

Child's dentist \_\_\_\_\_ Phone \_\_\_\_\_

Please describe any physical, medical, or psychological concerns that would be helpful to treatment.

Are there any other family members with a similar background? Who, what, and treatment received.

Any surgeries/injuries (include dates)? \_\_\_\_\_  
Any vision or hearing issues, ear infections/strep (include approximate ages and frequency), allergies, difficulty with coordination, etc.? \_\_\_\_\_

Does your child have a medical/psychological diagnosis? Yes/No. Please describe (give dates also) \_\_\_\_\_

Does your child take medication regularly? Yes/No

Name/dosage/Prescribing MD	Purpose	Date Began	Effects of medication

Has your child ever been hospitalized for psychiatric reasons? \_\_\_\_\_  
If so, please give dates, reason, and location: \_\_\_\_\_

Does your child receive any other services or has s/he had any recent evaluations (eg.psychiatric, OT, PT, speech, etc)?

Treatment/Eval. (circle)	Name of Provider	Phone #	Dates of Service	Purpose
T/E				
T/E				

**Developmental Background (approximate timing is fine)**

Age of first words: \_\_\_\_\_

Age of toilet training \_\_\_\_\_

Was toilet training easy, difficult, etc./Any issues? \_\_\_\_\_

How does your child handle changes in routine? \_\_\_\_\_

Please note specific situations in which your child tends to become upset, angry, scared, withdrawn, etc.

Describe how you help your child handle these situations \_\_\_\_\_

How would you describe your child's temperament/personality? \_\_\_\_\_

Describe your approach to discipline and how your child responds \_\_\_\_\_

What are your child's social strengths/areas for improvement? \_\_\_\_\_

Does your child make friends with peers easily? \_\_\_\_\_

Does s/he show interest in other adults easily or cautiously? \_\_\_\_\_

How does your child interact with friends? \_\_\_\_\_

What time does your child go to bed? \_\_\_\_\_ What time does s/he wake up? \_\_\_\_\_

Does s/he have any issues with falling asleep, staying asleep, or bedwetting? Describe \_\_\_\_\_

Please describe your child's eating habits/appetite \_\_\_\_\_

### **School Background**

Previous Schools Attended \_\_\_\_\_

Describe your child's previous school experiences \_\_\_\_\_

How does your child perform academically? \_\_\_\_\_

How does your child perform socially in school? \_\_\_\_\_

How does your child feel about school? \_\_\_\_\_

Please list comments/concerns expressed by teachers/school staff about your child \_\_\_\_\_

Has your child ever received school-based social work services or other school-based services? Yes/No. Please describe these services (e.g. Were they provided individually/in groups? What issues were addressed?) \_\_\_\_\_

If so, how frequently and during which grade(s)? \_\_\_\_\_

Were services helpful? Why or why not? \_\_\_\_\_

Does your child have an IEP or 504 plan at school? Yes/No. If so, please describe the services your child receives: \_\_\_\_\_

\*\*\*If your child receives an IEP/504 plan, please provide us with a copy, so that we can collaborate on services and help your child obtain goals as best as we can in this setting.

### **Strengths/Presenting Problems**

Please describe 3 of your child's strengths: \_\_\_\_\_

What concerns do you have about your child? \_\_\_\_\_

What goals/assistance would you like to obtain during social work treatment? \_\_\_\_\_

Anything else you would like to discuss (please feel free to use additional pieces of paper)

Available times/days for your child to come to therapy \_\_\_\_\_

*Thank you for taking the time to complete this questionnaire. This information helps us greatly in providing the best services for you and your child.*