Developmental History/Current Strengths & Needs

Today's Date:______________________________________
Name of Person(s)/ Completing Form: ____
Relationship(s) to Client (if not client) ____
Why are you seeking treatment at this time? ____
____
How were you referred to us? ____

Personal Information (Complete with Client's Info):
Name ___________________________ Date of Birth_____________ Age____ Gender _________
Home Phone___________________ Cell Phone __________________
Parent's phone (if live with parents- we will only contact if you give consent) ______________________
Email address that you check on a daily basis ____
Address____
School/Work____Years attended/worked______________
School/Work's phone #:_____________________________Advisor/Boss__________________________
Client lives with ____Please list names/dates of birth of any siblings, if they live with you____
Do you have a caregiver other than yourself? Yes/No If yes, how often? __________________________
Any pets? Yes/No. Type of pet(s) and name(s): ____

Insurance Coverage:
Please complete this information on our HIPAA compliant online program with the login and password information provided to you.

Family Background

Client's marital status __________________ Date(s) ____
If living with parent, parents' marital status __________________ Date(s) _________________________
Do you have a guardian? _____________ Do you have any children? _______________________
Any family crisis/emergent situation we should be aware of? ___________________________________
____
Family's religious preference: ______________________Church/synagogue attends ________________
Are you adopted? Yes/No. If yes, where and at what age? ______________________________________
If you answered yes, what information did you receive about your adoption, and/or birth family? ______
____
Mother/Parent's name (if client lives with parents): ____
Date of Birth _________________
Mother/parent's address (if different than client) ____
Education: ___________________________________Mother's occupation _________________________
Employer Name/Location ____
Does Mom/parent travel for work?__________ How often? _______________________________
Father/Parent's name (if client lives with parents):_____________________ Date of Birth _________
Father/parent's address (if different than client) ____
____
Education: ____
Father/parent's occupation ______________________ Employer Name/Location ____________________
Does Dad/parent travel for work?_____________ How often?____________________________________

Have there been any recent family/work/health changes? Describe: ______________________________
____
How have you been reacting to this/these change(s)?
____

What activities do you enjoy doing? ____
____
Describe your relationship with family members____
____
If you live with your one/both parents, how would you describe parents' relationship with each other?
____
____
Describe your mother's/parent's parenting style/approach with you. ______________________________
____
Describe your father's/parent's parenting style/approach with you. ______________________________
____
Your current tobacco/alcohol/drug use:
____
____

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

Please list if there were any complications with your birth: _____________________________________
Were any medications prescribed to your mother? Yes/No. Their purpose _________________________
____
How much alcohol did your mother consume during pregnancy? _______________________________
Any illicit drugs used during your mother's pregnancy? Yes/No. Name of drug(s)/how often used:
____
____
Please list any complications with your mother's conception, pregnancy, childbirth: ________________
____
____
Were you born full term? ______

Health Background

Primary Doctor____ Phone ______________________
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, frequent infections (include approximate ages and frequency), allergies, difficulty with coordination, etc.? ____
____
Do you or have you had a medical/psychological diagnosis or Trauma History? Please describe/when?
____
____
____
____

Do you take medication regularly? Yes/No

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

Have you ever been hospitalized for psychiatric reasons?___________________________________
If so, please give dates, reason, and location: ____
____

Do you 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)

Any delays in speech or toilet training as a child? Describe: ____________________________________
How do you handle changes in routine? ____
____
____

Please note specific situations in which you become emotional: upset, angry, scared, withdrawn, etc.
____
____
____

Describe what, if anything, helps you handle these situations ___________________________________
____
____

How would you describe your temperament/personality? _________________________________
____

Describe how you respond to negative feedback/criticism now and in the past: __________________
____

What are your social strengths/areas for improvement? _____________________________________
____

How do you make connections with peers, get along with bosses/coworkers, roommates, spouse, etc?
____
____

Would you describe yourself as more of an introvert or extravert? ________________________________
____

How do you get along with friends? ____
____

What kinds of friends are you drawn to? ____

What time do you typically go to bed?_________ What time do you wake up?_____________________
Do you have any issues with falling asleep, staying asleep, etc? Describe ________________________
____

Please describe your eating habits/appetite/hygiene/exercise_________________________________
____

School Background

Describe your school experiences ____
____

How did you perform academically? ____

How did you perform socially in school? ____
____
How do you feel about school/work? ____
____

What are your career aspirations? ____
Please list comments/concerns expressed by teachers/school staff or employers _____________________
____
____
Have you ever received therapy services? Yes/No. Please describe these services (e.g Were they provided individually/in groups? What issues were addressed?) _________________________________
____
____
____
When did you receive these services?____
____
____
Were services helpful? Why or why not? ____
____
Did you ever receive additional help or services at school? Yes/No. If so, please describe the services received:
____
____
***If you are currently receiving services in an IEP/504 plan, please provide us with a copy, so that we can collaborate on services and help obtain goals as best as we can in this setting.

Strengths/Presenting Problems

Please describe 3 strengths: ____
____
What concerns do you have? ____
____
____
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 you 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 family member.