North Shore Family Services

Developmental History/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 _____ Client's phone _____
Email address that you check on a daily basis _____
Address_____
Client's School/Work_____Years attended/worked_____
School's phone #:_____ Advisor/Boss_____
Client lives with _____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 Company _____ PPO/HMO (circle)
ID # _____ Group # _____ Copay Amount _____
Is there a secondary insurance policy? Yes/No. If so, secondary policy information _____

Family Background

Client's marital status _____ Date(s) _____
Parents' marital status _____ Date(s) _____
Does client have a guardian? _____ Does client have any children? _____
Any family crisis we should be aware of? _____
Family's religious preference: _____Church/synagogue attends _____
Is client adopted? Yes/No. If yes, where and at what age? _____
If client is adopted, what does child know about the 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 changes? Yes/No. Describe: ________________________________
____
If yes, what was the client told about change(s) in the family?________________________________
How did the cllient react? ____

What activities does s/he enjoy doing? ____
____
Describe client's relationship with Mom/parent____
What does client do with Mom/parent? ____
____
Describe client's relationship with Dad/parent
____
____
What does client do with Dad/parent? ____
____
Describe client'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 client. _________________________________
____
Describe Dad/parent's parenting style/approach with this client. _________________________________
____
Client's 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 client born full term? ______ How many weeks gestation? _____Vaginal/C-section ____________
Weight at birth_____________________ Length at birth__________________

Health Background

Client's Primary Doctor_______________________________________ Phone ______________________
Client'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 client have a medical/psychological diagnosis? Yes/No. Please describe (give dates also) _____

_____

_____

Does client take medication regularly? Yes/No

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

Has client ever been hospitalized for psychiatric reasons?_____

If so, please give dates, reason, and location: _____

_____

Does client 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 client handle changes in routine? _____

_____

_____

Please note specific situations in which client becomes emotional: upset, angry, scared, withdrawn, etc.

_____

_____

_____

Describe what, if anything, helps client handle these situations _____

_____

_____

How would you describe client's temperament/personality? _____

_____

Describe how client responds to negative feedback/criticism now and in the past: _____

_____

What are client's social strengths/areas for improvement? _____

_____

How does client make connections with peers, get along with bosses/coworkers, roommates, etc? _____

_____

_____

Does s/he show interest in others easily or cautiously? _____

How does client interact with friends? _____

_____

What kinds of friends is client drawn to? _____

What time does client go to bed?_____ What time does s/he wake up?_____
Does s/he have any issues with falling asleep, staying asleep, etc? Describe _____
_____
Please describe client's eating habits/appetite/hygiene_____
_____

School Background

Previous Schools Attended _____
Describe client's previous school experiences _____
_____
How did client perform academically? _____
How did client perform socially in school? _____
_____
How does client feel about school/work? _____
_____

What are future career choices/paths? _____
Please list comments/concerns expressed by teachers/school staff/employers _____
_____

Has client 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? _____
_____
Did client have an IEP or 504 plan at school? Yes/No. If so, please describe the services received:
_____
_____
***If client received 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 about client? _____
_____
_____
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 client and/or 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.