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.