



## 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:

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's phone #: \_\_\_\_\_ Advisor/Boss \_\_\_\_\_

Client lives with \_\_\_\_\_ Please list names/dates of birth of  
any siblings if they live with client \_\_\_\_\_

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:

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 # See Client Information Sheet Group # \_\_\_\_\_ Copay Amount \_\_\_\_\_

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

### 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 changes? Yes/No. Describe: \_\_\_\_\_

How have you been reacting to this change?  
\_\_\_\_\_

What activities do you enjoy doing? \_\_\_\_\_

Describe client's 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. \_\_\_\_\_

Current tobacco/alcohol/drug use: \_\_\_\_\_

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

Please 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**

Your 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, frequent infections (include approximate ages and frequency), allergies, difficulty with coordination, etc.? \_\_\_\_\_

Do you or have you had a medical/psychological diagnosis? Yes/No. Please describe (give dates also) \_\_\_\_\_

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 becomes 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.*