North Shore Family Services

Developmental 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.