Developmental History and Current Strengths/Needs

Today's Date:______________________________

Name of Client ______________________________ Date of Birth ______________________________

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 _________

Address______________________________

Home Phone___________________ Cell Phone __________________ Child's phone _______________

Email address that you check on a daily basis ______________________________

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:

Please complete online with link and password sent to your email you provided.

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? ______________________________

Who has decision-making authority for behavioral health services? Please circle: Mom(s)/Dad(s)/Both/Neither

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: ______________________________

____

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. ______________________________
____
What are your parenting concerns (if any)? ____
____
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)? If so, please provide names and contact information on our Consent form.

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 our North Shore Family Services staff in providing the best services for you and your child.