



Intake Information for Social Work Services

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's name (if client lives with parents): _____

Date of Birth _____

Mother's address (if different than client) _____

Education: _____

Mother's occupation _____ Employer Name/Location _____

Does Mom travel for work? _____ How often? _____

Father's name (if client lives with parents): _____ Date of Birth _____

Father's address (if different than client) _____

Education: _____

Father's occupation _____ Employer Name/Location _____

Does Dad 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 child react? _____

What activities does s/he enjoy doing? _____

Describe client's relationship with Mom _____

What does client do with Mom? _____

Describe child's relationship with Dad _____

What does client do with Dad? _____

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's parenting style/approach with this client. _____

Describe Dad's parenting style/approach with this client. _____

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 _____

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 |
|----------------------------|---------|------------|-----------------------|
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| | | | |
| | | | |

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 your approach to discipline and how client responds now and in the past: _____

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

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

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

How does client interact with friends? _____

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 your child'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 _____

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? _____

Does your child have an IEP or 504 plan at school? Yes/No. If so, please describe the services received:

***If client 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 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 child.*