North Shore Family Services

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 (Complete with Client's Info):
Name _____ Date of Birth_____ Age____ Gender _____
Home Phone_____ Cell Phone _____
Parents'phone (if you live with parents- we will only contact if you give consent_____
Email address that you check on a daily basis _____
Address_____
School/Place of Employment_____Years attended/worked_____
Highest Level of Education _____
School/Work phone #:_____Advisor/Boss_____
Please list names/dates of birth of any other family members who live with you_____
_____
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:
Please complete this information on our HIPAA compliant online program with the login and password information provided to you.

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? _____Ages_____
Any family crisis/emergent situation we should be aware of? _____
_____
Family's religious preference: _____Church/synagogue attends _____
Mother/Parent's name (skip if you don't live with parents): _____
Date of Birth _____ Is your mother still living?_____
Father/ Parent's name (skip if you don't live with parents): _____
Date of Birth _____ Is your father still living?_____
Have there been any recent family/work/health changes? Describe: _____
_____
How have you been reacting to these changes? _____
_____
What activities do you enjoy doing? _____
_____
Describe your relationship with family members_____
_____

Describe your relationship with friends_____

_____

Describe your relationship with your partner_____

_____

How would you describe your 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. _____

_____

Your current tobacco/alcohol/drug use: _____

_____

Childhood Background

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? _____

_____

Were you born full term? _____

Please list any complications with your birth/childhood illnesses/trauma/etc. _____

_____

_____

Any delays in speech or toilet training as a child? Describe: _____

Health Background

Primary Doctor_____ Phone _____

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 or Trauma History? Please describe/when?

_____

_____

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 have 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

Social/Emotional Background/Coping Skills

How do you handle changes in routine? _____

_____

_____

Please note specific situations in which you become 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 extrovert? _____

_____

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 counseling?_____

_____

_____

How will you know when counseling is complete? _____

_____

_____

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.