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SOCIAL HISTORY

In order to understand your child better, we would like you to complete this questionnaire. If you have questions about any information here, please ask your doctor/therapist.

Child/Adolescent's Name: _____ Who completed this form? _____

Why are you are seeking therapy for your child at this time?

Is there anything that may have triggered these changes?

Are there any other concerns that you have?

Please check any of the following which apply to your child:

Problem	Yes	No	Describe
School Problems			
Difficulty getting along with others			
Depression, sadness			
Fears, worries, anxieties			
Acts without thinking, impulsive			
Suicidal thoughts or attempts			
Confused, strange, or bizarre behavior			
Juvenile delinquency (running away, vandalism, theft)			
Frequent disobedience			
Can't pay attention for long, can't concentrate			
Identity problems			
Sexual problems			
Eating problems			
Family conflict			
Aggressive behaviors (fighting, hitting, threatening others)			
Problems with drugs or alcohol			
Other:			

YOUR CHILD'S DEVELOPMENTAL HISTORY:

Briefly describe any problems in the child's mother's pregnancy and/or childbirth: _____

_____

List any drugs, legal or illegal including alcohol, used by mother or father at time of conception, or by mother during pregnancy:

_____

Please fill in when the following developmental milestones took place:

Behavior	Age began	Comments
Walking	_____	_____
Talking	_____	_____
Toilet trained	_____	_____

Please rate your opinion of the child's development (compared to others the same age) in the following areas:

	Below Average	About Average	Above Average
Social Skills	_____	_____	_____
Physical Skills	_____	_____	_____
Language Skills	_____	_____	_____
Intellectual Ability	_____	_____	_____
Emotional Stability	_____	_____	_____

YOUR CHILD'S MEDICAL HISTORY:

CURRENT HEALTH	YES	NO	DESCRIBE
Allergies			
Current medical problems			
Does patient take any medications			
currently? (Include			
prescribed or frequently used			
over the counter meds.)			
Headaches			
Blackouts			
Seizures			
Tics/nervous habits			
Visual problems			
Hearing loss			
Speech problems			
Change in appetite			
Insomnia (trouble sleeping)			
Too much sleeping			
Fatigue/tired			
Vomiting			
Stomach aches			
Frequent colds			
Coughs			
Asthma			
Enuresis (bedwetting)			
Encopresis (soiling)			
Diarrhea			
Constipation			
Rashes/acne			
Heart problems			
Learning Disability			
History of head injury/loss of consciousness			
Past History:			
Previous surgeries			
Previous hospitalization			
Family history of heart rhythm problems			

***** YOUR CHILD'S PHYSICIAN:** _____

YOUR CHILD'S BEHAVIORAL AND EMOTIONAL HISTORY:

Has your child seen a psychiatrist, psychologist or counselor before or been in a hospital or other treatment program?

Dates	Therapist/Program/Hospital	Diagnosis	Medication(s)	Response

YOUR CHILD'S EDUCATIONAL HISTORY:

Grade	School	Grades	Conduct

YOUR CHILD'S SOCIAL DEVELOPMENT:

How many friends does your child have? _____

Do you have any concerns about your child's relationships?

Does your child belong to any youth groups, involved with teams or in other activities?

List some of your child's strengths:

_____

_____

Because the family is so important to a child's well-being, we would like you to answer some questions about your family.

FAMILY HISTORY:

Please list household members:

Name	Sex	Relationship	Age	Education

Has your child ever lived with anyone for an extended period of time besides you? If yes, please explain:

Describe the relationship between the child and the adults in your household?

How well does your child get along with other children in the home?

Do you and the child's other parent live together? Yes _____ No _____ If not, please explain:

Which style of discipline is used in the household. Check all that apply:

_____time out ____loss of privileges ____spanking ____removal of toys, etc. ____yelling

_____talking to ____sending to room ____other:_____

Has anyone in your family experienced any of the following? ____ADHD _____mood swings

____depression ____anxiety ____anger ____suicide attempts ____heavy drinking

____drug abuse ____temper problems ____emotional problems ____mental retardation ____other

Please describe: _____

What are some of the stressful events (positive and negative) which your family has experienced? Please indicate the age of the child:at that time.
(e.g. move, new school, deaths/losses, divorce, serious illness of child or family members, serious financial difficulties, birth of siblings, new marriage, legal matters,, witness of violence, etc.)

Is there a history of abuse or do you have concerns about abuse to this child?

THANK YOU

I have answered the questions on this social history to the best of my knowledge.

_____

Signature of Parent/guardian *Date*