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SOCIAL HISTORY-**CONFIDENTIAL**

NAME: DOB:

ADDRESS: BIRTHPLACE:

CITY: SCHOOL:
STATE/ZIP: NY / GRADE:

TELEPHONE:

DATE:

PRESENTING ISSUES: (brief description)

FAMILY CONSTELLATION:

NAME: DOB/BIRTHPLACE: EDUCATION: OCCUPATION:

Please indicate who lives in the home with an asterisk to the left of their name

If parents are separated or divorced, who has custody of this child?

How often does the other parent see this child?

DEVELOPMENTAL HISTORY

1. Birth and Early Infancy: (pregnancy-mother's health, medications, miscarriages, delivery-complications, birth weight, baby's medical condition)

2. Developmental Milestones:

   Age of walking:

   Age of talking—words: sentences:

   Age of toilet training:

   Challenges reaching developmental milestones:

   Did your child receive Early Intervention services? If so, at what age and what services?

3. Eating Habits: (breast fed or bottle fed, describe any problems as an infant, giving up the bottle, switching to food, appetite, likes/dislikes, mealtime behavior)

4. Health: (serious illnesses, hospitalizations, accidents, ear-throat infections, colds, allergies to food/medicine/seasons, high fevers, hearing and/or vision problems, medications, immunizations)

Who is your child's pediatrician?

MENTAL HEALTH HISTORY

A. Has your child received any counseling? If so, at what age and with whom? What issues were addressed? Was it helpful?

B. Has your child ever had a neurological, psychological or psychiatric evaluation? If so, at what age and by whom? What were the results?

C. Does your child take any medication on an ongoing basis? If so, what medication and dosage? What are they being treated for? When did your child begin taking medication?

D. Are there any family medical/mental health history and/or present concerns?

E. Is there any family history of mental illness or drug/alcohol abuse?

5. Problem Areas in Child's Development: (Bedwetting, Sleeping-how many hours? Restless, walking, talking, grinding teeth, nightmares during sleep? Thumb sucking, nail biting, rocking, banging, nervous tics, temper outbursts, crying, moody, unusual fears, short attention span)

EDUCATION: (list all schools chronologically, including pre-school and kindergarten, with date and age attended)

A. Please note child's adjustment and progress as well as any attendance problems (past or present). Also, please indicate if there have been any extra services provided and please explain your child's attitude towards school.

B. Please describe the experiences of parents and siblings in school-difficulties they may have had (learning, speech, emotional, behavioral), parents' understanding of child's problems, parents' expectations of the child and school personnel.

SOCIAL DEVELOPMENT

1. Leisure activities—after-school programs, group or organized activities (past and present), summer programs, hobbies, family activities.

2. Social relationships—friends-many/few, own age or younger/older, solitary vs. group play, how he/she relates to others.

3. Family life—how does he/she get along with each family member, activities shared with the family, how much time spent together, responsibilities expected of the child.

4. What is the primary language spoken at home? What other languages (if any) are spoken at home?

5. How is your child disciplined at home? How does he/she respond to discipline?

6. Are there any concerns about your child's emotional development, behavior or choice of friends?

7. What are your child's strengths and weaknesses?

Please check off which problems / symptoms apply to your child/adolescent currently:

sad/depressed mood: at times ☐ anxious/tense: ☐

withdrawn: ☐ fatigue: ☐

panic attacks: ☐ angry outbursts: has improved ☐

decreased appetite: ☐ increased appetite: ☐

excessive weight loss: ☐ purging: ☐

increased sleep: ☐ difficulty falling asleep: ☐

early morning waking: ☐ nightmares: ☐

poor attention/concentration: ☐ hyperactivity: ☐

poor academic performance: ☐ truancy: ☐

oppositional/defiant: ☐ stealing: ☐

drug use: ☐ alcohol use: ☐

suicidal thoughts: ☐ suicide attempt: ☐

self-injurious behavior without intent to die (e.g. self-cutting): ☐

hearing voices/sounds: ☐ seeing things other people don't see: ☐

inappropriate sexual behavior: ☐ physical aggression/fighting: ☐

poor peer relationships: ☐ poor family relationships: ☐

Please use this space to describe any other issues, questions, or concerns you have about your child/adolescent.

Parent Signature Date