



Social History- Child & Adolescent

When a therapist begins working with a child, we find that certain basic information provided to us by the parent can be useful. We greatly appreciate your time and cooperation. We realize that some of the questions are difficult to remember and answer. Please try to give details as the more we know about your child, the better job we can do.

Child's Name: _____ Today's Date: _____

Child's Address: _____

Phone Number: (Home) _____ Parent's Work/Cell Number: _____

Birth date: _____ Age: _____ SS#: _____

Biological Father: _____ Biological Mother: _____

Other Guardian (Relationship): _____

Reason for seeking help: _____

Problems your child is having at home: _____

Problems your child is having at school: _____

School: _____ City: _____

Grade level: _____ Teacher's Name: _____

School conference this year: ___ No ___ Yes If yes, please describe outcome: _____

Is this a school referral? ___ No ___ Yes If, yes, what is the reason for the referral: _____

PARENTAL HISTORY

BIOLOGICAL FATHER: Birthplace: _____ Birth date: _____

Educational Attainment: _____

Did you have difficulty in school? ___ No ___ Yes If yes, please explain: _____

Did any member of your family have difficulty in school? ___ No ___ Yes If yes, please explain: _____

Place of Employment: _____ Hours: _____

Occupation: _____

Other Marriages: _____

Past Physical or Mental Problems: _____

Patient Name _____

Client id _____

BIOLOGICAL MOTHER: Birthplace: _____ Birth date: _____

Educational Attainment: _____

Did you have difficulty in school? ___ No ___ Yes If yes, please explain. _____

Did any member of your family have difficulty in school? ___ No ___ Yes If yes, please explain: _____

Place of Employment: _____ Hours: _____

Occupation: _____

Other Marriages: _____

Past Physical or Mental Problems: _____

PRESENT MARITAL SITUATION ___ Married & Living Together ___ Separated ___ Divorced
___ Widowed ___ Never Married

Number of years in present marriage: _____

In describing your current marriage would you say:

___ Very poor situation ___ tolerate each other ___ relatively happy ___ happy ___ very happy

Additional Comments: _____

If remarried since the birth of this child, how old was (s)he:

when you divorced? _____ when you remarried? _____

If separated/divorced, who has primary physical custody? _____

Stepfather or Significant Other's Name _____

Stepmother or Significant Other's Name: _____

What are the legal custody arrangements? _____

BIRTH HISTORY

Birth: ___ Full term ___ Premature ___ weeks Length of Labor: _____ Anesthesia? ___ Yes ___ No

Complications during pregnancy: ___ None ___ Bleeding ___ Special Medication ___ Toxemia

___ Diabetes ___ RH factor ___ Other: _____

Labor induced? ___ No ___ Yes If yes, please give reason: _____

Problems immediately after birth? ___ No ___ Yes If Yes, please explain: _____

Placed in an incubator? ___ No ___ Yes Birth Weight: _____ Fed normally? ___ No ___ Yes

When held, was (s)he: ___ Rigid ___ Relaxed Colic: ___ No ___ Yes If yes, how long: _____

Physical defects? ___ No ___ Yes If yes, please describe: _____

Irritability? ___ No ___ Yes Difficulty sleeping? ___ No ___ Yes If yes, please explain: _____

Patient Name _____

Client id _____

CHILDHOOD HISTORY

At approximately what age did the following occur:

Held head up: _____ Crawled: _____ Sat Alone: _____ Walked: _____

First word: _____ Sentences: _____ Toilet Trained: _____ Dressed alone: _____

Difficulty using (check all that apply): ___ Scissors ___ Coloring ___ Writing ___ Other: _____

Comparison of development to that of brothers and/or sisters: _____

Describe child as a toddler: _____

Handed: ___ Left ___ Right High Fevers: ___ No ___ Yes

Convulsions/staring spells: ___ No ___ Yes Hearing Impairment: ___ No ___ Yes

Ear Infections: ___ No ___ Yes If yes, how many? _____

Visual impairment: ___ No ___ Yes If yes, please explain: _____

Speech impairment: ___ No ___ Yes If yes, please explain: _____

Injuries or accidents (particularly blows to the head): _____

Describe child's health: _____

Describe any medical conditions: _____

Current medications and dosages: MD _____

Allergies: _____

DAILY SCHEDULE

Sleep Pattern: ___ Normal ___ Very sound ___ Restless ___ Nightmares Number of Hours Sleep: _____

Bedtime: _____ Time of Waking: _____ Resist sleep? ___ No ___ Yes

Security Items? ___ No ___ Yes If yes, please describe _____

General appetite and eating habits: _____

Child care arrangements: _____

CHURCH ATTENDANCE

What church do you attend: _____

How often do you attend church: ___ Regularly ___ Occasionally ___ Seldom ___ Never

Briefly describe your present involvement in your church _____

Patient Name _____

Client id _____

FAMILY RELATIONSHIPS

List brothers and sisters in birth order and give their current ages:

Significant health or emotional problems with other children: _____

Describe sibling rivalry or jealousy: _____

Does this child particularly like or relate well to any other brother or sister? ___ No ___ Yes.

If yes, please describe: _____

Do children generally get along? ___ Yes ___ No If no, please describe: _____

Describe the father-child relationship: _____

Describe the mother-child relationship: _____

Describe relationship with significant caregiver: _____

Family Activities: _____

Activities with father: _____

Activities with mother: _____

Discipline Type: _____ Consistent? ___ No ___ Yes

Who administers discipline: _____

Child's reaction to frustration: _____

Child's Responsibilities: _____

Allowance? ___ No ___ Yes If yes, how much? _____ How is it used? _____

EDUCATIONAL INFORMATION

Academic progress: _____

Your expectations: _____

Schools Attended	Grade Level	Performance
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child's attitude toward school: _____

Unpleasant School Experiences: _____

Grades retained and why: _____

Patient Name _____ Client id _____

Most Difficult Subject: _____ Resist attending school? No Yes
Best Subject: _____ Reads other than assigned books? No Yes
Where does (s)he study: _____ Parents help? No Yes
Other comments on school: _____

Testing administered (school or private): _____
Describe home environment (house, apartment, ample play space, neighbors close by, type of neighborhood):

Describe child's social relationships: _____
Describe child's bedroom (share a room, help pick-up, interest in decorating): _____

Personality of Child (Check all that apply):		Activity level of Child (Check all that apply):	
<input type="checkbox"/> anxious	<input type="checkbox"/> depressed	<input type="checkbox"/> active	<input type="checkbox"/> prefers quiet play
<input type="checkbox"/> introverted	<input type="checkbox"/> social	<input type="checkbox"/> aggressive	<input type="checkbox"/> impulsive
<input type="checkbox"/> extroverted	<input type="checkbox"/> happy	<input type="checkbox"/> organized	<input type="checkbox"/> loses things easily
<input type="checkbox"/> unhappy	<input type="checkbox"/> imaginative	<input type="checkbox"/> difficulty remembering	
<input type="checkbox"/> loner	<input type="checkbox"/> sensitive		

Additional information or comments: _____

Patient Signature _____ **Date** _____

Patient Name _____ Client id _____