St. Joseph's Children's Home
P.O. Box 1117, 1419 Main Street, Torrington, WY 82240
Phone: (307)532-4197 Fax: (307)532-4024

SOCIAL HISTORY FORM

Instructions: Parent or most recent relative care provider, please fill out the form below in its entirety.

Date: ____/_____/_____ **Resident Number: _____**
(For office use only)

Identifying Information

Resident Name: _____ ***SS#***_____
Sex: (M)___ (F)_____ DOB: ____/_____/_____ Current Age: _____ Place of Birth: _____
Ethnic origin (check all that apply):
__ African American __Asian or Pacific Islander __Hispanic __Native American __White __Other: _____

Name of person completing form: _____Relationship to child: _____
Phone Number: (_____)_____-_____ Indicate best time for a follow-up call: _____
Mailing Address: _____ City: _____ State: _____ ZIP Code: _____

Child's primary caregiver: _____ Relationship to child: _____
Mailing Address: _____ City: _____ State: _____ ZIP Code: _____
Phone #: (___)_____ E-mail Address: _____

Primary reason for referral and admission to St. Joseph's Children's Home:
_____
_____

What would be the desired outcome of the child's placement here?
_____
_____
Do you agree with this placement? __Yes __Don't Know __No Explain: _____
Does your child agree with the placement? __Yes __Don't Know __ No
Do you plan that your child will return to your home: _Yes __No __ Don't Know
Would you like more information about your child's disorder, challenges, needs? __Yes __ No
How long do you think your child will receive treatment at St.Joseph's Children's Home: _____

Please describe your child's strengths/positive qualities:
1. _____
2. _____
3. _____

Coping Skills/Triggers

Please describe effective coping skills used by the child:_____
_____

Please describe internal triggers that lead to concerning behaviors:_____
_____

Please describe external triggers that lead to concerning behaviors:_____
_____

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Mental Health Treatment History

Outpatient Treatment History Please check any of the following that apply:
__ Psychiatrist(s) __Psychologist __Therapist __ Psychological Evaluation __ Psychiatric Evaluation
__ Neurological Evaluation __ Wraparound Services **(Provide details below)**

Dates of Treatment	Name of Provider	Reason for treatment	Outcome of treatment

Inpatient/Out of Home Treatment History
__Has received treatment at an inpatient facility **(Provide details below)**

Dates of Treatment	Name of Provider	Reason for treatment	Outcome of treatment

Behavior: Please check and include the age your child was exposed to the following:

Behavior or Action	√	Age	Behavior or Action	√	Age
Death of a parent			**Witnessed a traumatic event**		
Death of a close family member			**Witnessed a lot of violence**		
Death of a close friend			**Inappropriate internet usage**		

Thinking/Communication Please check the appropriate response for your child on the following: Does your child:
__No __Don't Know __Yes Frequently repeats words that others say (like a parrot)
__No __Don't Know __Yes Frequently uses words that only have meaning to him/herself ?
__No __Don't Know __Yes Does not make any sense when talking, even though he/she is using common words?
__No __Don't Know __Yes Makes sense when he/she talks, but it is not related to the topic?
__No __Don't Know __Yes Believes things that are obviously not true?
__No __Don't Know __Yes Believes that just by thinking something, you can make it happen?
If you checked yes on any of the above, please explain: _____
_____

Family Information **Marital Status of Biological Parents (Please check all that apply, and provide dates):**
__ Never married __Married for _____yrs. Date of Marriage _____ ___ Separated (date): _____
__Divorced (date):_____ __Widowed (date): _____

Biological Father/Adoptive Father

Name: _____ DOB: ____/_____/_____
Mailing Address:_____City: _____ State:_____
ZIP Code: _____Phone Number: (_____)_____-_____ E-mail _____
Currently Employed: __Yes __No Occupation: _____
Present Employer: _____ Work Phone Number (_____)_____-_____
How involved is this individual with the child currently? _____
How stable is the individual's relationship with the child? _____

Biological Mother/Adoptive Mother

Name: _____ DOB: ____/_____/_____
Mailing Address: _____City: _____ State:_____
ZIP Code: _____ Phone Number: (_____)_____-_____ E-mail_____
Currently Employed: __Yes __No Occupation: _____
Present Employer: _____ Work Phone Number (_____)_____-_____
How involved is this individual with the child currently? _____
How stable is the individual's relationship with the child? _____

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Step Parent/Significant Other

Name: _____ DOB: ____/_____/_____
Mailing Address:_____City:_____ State:_____
ZIP Code: _____Phone Number: (_____)_____-_____ E-mail _____
Date of Marriage _____
Currently Employed: __Yes __No Occupation: _____
Present Employer: _____ Work Phone Number: (_____)_____-_____
How involved is this individual with the child currently? _____
How stable is the individual's relationship with the child? _____

Who is currently living in the home?

__Biological Father __Biological Mother __Adoptive Father __Adoptive Mother
__Grandparent __Stepmother __Stepfather __Foster Parent
__Siblings __ Others: list names and relationship to family/child _____

Siblings: **Instructions**: Please complete below for sibling information.
Use the following for relationship: Full Sibling, Half Sibling, Step Sibling, Foster SiblingCurrent living situation means either in the family home or outside of the family home.

Name	Age	Sex	Relationship	Current living situation

Religious Preferences:

Of Child: _____ Of Family: _____

Family Psychosocial History:

In all known blood relations, please list each person with any history of the following:
Diabetes: _____
Thyroid problems :_____
Other glandular (endocrine) disease(s): _____
Alcohol problems: _____
Drug problems: _____
Attention problems: _____
Mental retardation: _____
Behavioral problems: _____
History of seeing a psychiatrist or counselor: _____
Sexual abuse victim: _____
Sexual abuse offender: _____
Suicide attempts: _____
Successful suicides: _____
Diagnosed mental illness: _____
_____

Please describe any other family information, such as other siblings or family members receiving out of home treatment, you think might be helpful in your child's treatment:
_____
_____
_____

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Developmental History

Adopted child: Was the Child adopted? __No __Yes. If yes, fill in any of the information you know in the following sections. Circumstances of adoption: _____

Prenatal Please, complete the following information (as much as you know):

Biological Father

Father's age at time of birth_____ Father's marital status at birth: _____
__Had a preference to sex of child? __No __Yes. If yes what sex: _____

Biological Mother

Mother's age at time of birth: _____ Mother's marital status at time of pregnancy_____
Mother's marital status at time of birth :_____
__Had a preference to sex of child? __No __Yes. If yes what sex: _____
Did mother use any of the following during pregnancy:
__Alcohol (amount used): _____ Smoked (amount used): _____
__Prescribed Meds: _____ Drugs (amount used): _____ Other: _____
Did mother make regular prenatal visits to the doctor? __No __Don't know __Yes
Did mother have problems with the following during pregnancy?
__Morning sickness __Toxemia __Gestational diabetes __Rh factor incompatibility __Other: _____
Were there any hospitalizations as a result of the above conditions? _____
_____

Birth

The child was born: __On schedule __Overdue, if so how long_____ Early, if so how early_____
How long was the mother in labor? _____
Were medications given while the mother was in labor? __No __Don't Know __Yes
If yes, please explain: _____
Were they any indications of fetal distress during labor or delivery? __No __Don't Know __Yes
If yes, please explain: _____
The delivery was normal, breech, cesarean, induced, forceps? _____
What was the child's weight at birth: _____lbs., _____oz.
Did the child have any health complications immediately following birth? __No __Don't Know __Yes
If yes, please explain: _____
Did the child come home with the mother from the hospital? __No __Don't Know __Yes
If yes, please explain:_____

Infancy

Check any of the following that applied to the child:
__Early feeding problems __Colic __Sleep difficulties __Any congenital problem __Cried a lot __Seizures
__Liked to be cuddled__ Followed a schedule __Convulsions __High fever __Vision problems __Head injuries
If you answered yes to any of the above selections, please explain: _____
_____
How active was the child as an infant or toddler?
__Extremely active __More active than average __Average __Less active than average __Not at all active
How insistent was the child in having his or her needs met?
__Very __Pretty much __Average __Not very __Not at all
At what age did the child do the following?
Sit up without support___ Crawl____ Walk____ Use a single word____
Use a string of two or more words_____
At what age was the child toilet trained: Bowel____ Bladder____

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Medical History Has the child had any of the following illnesses or injuries? Please check all that apply and indicate the age at which the child had the illness/injury. Please explain those with an * below.

√	Illness/Accident	Age	√	Illness/Accident	Age
	High Fever			Weight problems	
	Scarlet Fever			Allergies	
	Encephalitis			Skin Problems	
	Meningitis			Asthma	
	Serious head injury			Headaches	
	Convulsions/Seizure			Stomach Problems	
	Earaches/ear infection			Accident Prone	
	Fainting			Anemia	
	Dizziness			High/Low blood pressure	
	Tonsillitis			Sinus Problems	
	Tonsils removed			Heart Problems	
	Hearing problems			Tuberculosis	
	Mumps			Lead poisoning	
	Measles			Whooping Cough	
	Chicken Pox			Surgery*	
	Stomach pumped			Hospital over night*	
	Eye injury			Rheumatic Fever	
	Stitches			Diabetes	
	Car Accident*			Kidney Infections	
	Vision Problems			Bladder Infection	
	Dental Problems			Urinary Tract Infection	
	Broken Bones*			Upper Respiratory Infect.	

Other: _____

Please provide additional information about all checked items under Medical History: _____
_____
_____

Primary Care Physician:_____ Location:_____
Date of Last Physical Exam:_____ Eye Exam:_____ Dental Exam:_____
Does your child wear glasses/corrective eyewear? ___Yes ___ No Contact lenses ____Yes _____No
Does your child have dental braces or a retainer ____Yes ____No
***Describe specific allergies (medication, food, environmental) _____**
_____

Medication Prescribed

Has your child ever been prescribed medication for behavioral problems? __No __Don't Know __Yes
If yes, please explain: _____
Current Medications:_____
Prescribing Physician:_____

Sexual Information:

Do you believe your child has been sexually active? __No __Don't Know __Yes
If yes, at what age did the sexual activity begin? ___
Have there been any pregnancies ____ Has there been any sexually transmitted diseases _____

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Alcohol and Drug Usage

To your knowledge, has your child used alcohol? __No __Don't Know __Yes
If yes, at what age did your child start using alcohol: _____
To your knowledge, has your child used drugs (include street drugs, glue, inhalants, misuse of prescriptions?
__No __Don't Know __Yes. If yes, at what age did your child start using drugs: _____
What kind of drugs? _____
Has your child used alcohol and/or drugs and not remembered what he/she did when using alcohol and/or drugs?
___No____ Don't Know_____ Yes
Does your child drink or do drugs alone? __No __Don't Know __Yes
Does your child have trouble stopping drinking or doing drugs once started? __No __Don't Know __Yes
Do you think your child needs help from problems with drugs and alcohol? __No __Don't Know __Yes
Does your child have any problems with any substances, which have not been asked about?
__No __Don't Know __Yes.
How often does your child use alcohol? ___Twice a week ____ 3-4 times week _____ Daily ____Weekends only
How often does your child use drugs? ____ Twice a week ____3-4 times week _____Daily _____Weekends only

Abuse History

Has your child been **neglected**? __No __Don't Know __Yes
Has your child been **verbally abused**? __No __Don't Know __Yes
Your child has been **physically abused** (__No __Don't Know __Yes)
Has your child been **sexually abused** or do you suspect that your child may have been sexually abused? __No
__Don't Know __Yes.

If you answered yes to any of the above, please explain (specify: by whom, when, and the frequency of the abuse or suspected abuse:

_____
_____
_____
_____

Was any of the above abuse reported, investigated, substantiated or brought to trial? __No __Yes __Don't Know

Please explain: _____
_____
_____
_____

Educational Information

Last School Attended:_____ Grade:_____
Is your child currently receiving special services/IEP? __No __Don't Know __ Yes
If receiving special services/IEP please state the reason:_____

Please describe any educational concerns or issues:_____

_____
_____

Thank you for the time and attention that you have given to completing this Social History. The information you have provided will assist St. Joseph's staff in providing services to your child. The information you have provided is confidential and will be reviewed only by authorized staff members. If you have any question regarding this form, please contact us. Attach additional sheets if required.