

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: _____

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	<input checked="" type="checkbox"/>	Age	Behavior or Action	<input checked="" type="checkbox"/>	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? _____

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 Sibling Current 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:

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 there 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 _____

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 _____

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.