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. ____

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Mental Health Treatment History

Outpatient Treatment History

Please check any of the following that apply: ____ Psychiatrist(s) ____Psychologist ____Psychotherapist
____ Completed Psychological Evaluation Date: __________ ____ Completed Psychiatric Evaluation Date: __________

____Other type of counselor

Dates of Treatment	Name of facility/therapist	Reason for treatment	Outcome of treatment

Inpatient Treatment History

____Has received treatment at an inpatient facility

Where: ________________________________ Dates: ____________________________

________________________________ ____________________________

________________________________ ____________________________

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 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): _______

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Biological 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

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 ___________________________

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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:____

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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.