



SOCIAL HISTORY QUESTIONNAIRE—CHILD FORM

This form is designed to provide your therapist with an overview of your child’s experiences and history to assist with his/her treatment. All information on this form is completely confidential.

Please fill out the form as completely as possible, giving details. If a question does not apply to your child, please indicate by writing N/A on the line provided.

Date form completed: _____

Child’s Name: _____ Sex: M / F

Age: _____ Birth Date: _____ Race: _____

Home Address: _____
(Street) (City) (Zip)

Home Phone: _____ Parent’s Cell Phone: _____

School: _____ Grade: _____ Special Classes: _____

Mother’s Name: _____ Age: _____ Education: _____

Occupation: _____

Father’s Name: _____ Age: _____ Education: _____

Occupation: _____

Are the child’s mother and father still married: _____

Date of Marriage: _____ Date of Separation/Divorce (if applicable): _____

If child was adopted, give age of child at time of adoption: _____

Step-Parents (if applicable):

Name	Age	Occupation	Date of Marriage
_____	_____	_____	_____
_____	_____	_____	_____

This child is in legal custody of: _____



Other Children in Family:
First & Last Name

Age

Others living in home: _____

Place a star (*) next to the names of the people who live in the child's home.

MAIN CONCERN: (Tell us about your child's difficulties, when/how they began & what you hope we can do to help):

Age at onset of problems: _____

What have you tried, thus far, to correct the problems (please be specific):

OTHER PROBLEMS: (nervous, fearful, depressed, peculiar behaviors, etc.)

FAMILY PROBLEMS OR MAJOR CHANGES

(Include marital problems, change in family structure, or any upsetting events):

PERSONALITY OF THE CHILD

Describe your child's personality: _____

Describe any recent changes in your child's personality: _____

Describe any stressors or incidents in your child's life that has affected his/her present behavior:

Who is the child very close to: _____

Describe his/her relationship with:

Mother: _____

Father: _____

Stepparents (if applicable): _____

Siblings: _____

What Kinds of discipline work best with this child (be specific): _____

Describe discipline style of Mother: _____

Describe discipline style of Father: _____

DEVELOPMENTAL HISTORY

Were there any complications during the pregnancy or delivery: _____

During the pregnancy, did the mother: Drink? _____ Smoke? _____ Use drugs? _____ How much? _____

List medications the mother took during pregnancy: _____

How active was the baby in the womb? _____

How was the mother's emotional state during the pregnancy? _____

As best you can remember, give the age at which your child was able to do each of the following things:

First smile _____

Pulled up _____

Sat alone _____

Crawled _____

Sat up _____

Walked with help _____

Walked alone _____

Used 4-10 words _____

Used sentences _____

Talked clearly _____

Said "No! No!" to everything _____

Held up arms to be picked up _____

Held cup to drink _____

Fed self _____

Used fork _____

Helped dress _____

Dressed self except for buttons _____

Stopped wetting at night _____

Toilet trained _____

Dry during the day _____

Please check any of the following that are presently problems:

Temper Tantrums _____

Impulsiveness _____

Sleep _____

Bedwetting _____

Dangerous Acts _____

Over-talkative _____

Messing in pants _____

Unusual Fears _____

Appetite _____

MEDICAL HISTORY

Name of your child's pediatrician: _____

Describe any illnesses, disorders or diseases your child currently has: _____

List any prior major illnesses: _____

Was he/she ever hospitalized (if so, when & why): _____

Has he/she ever had any head injuries: _____ When: _____

Was there a concussion: _____

Has the child ever had seizures: _____ How often: _____

At what age did they start: _____ When was the last one: _____

List current medications your child is taking:

Name	Reason	Dose	Prescribing Physician
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Does your child have any allergies? If yes, please list: _____

To your knowledge has your child ever used, or is presently using street drugs or alcohol (if so, which ones):

MENTAL HEALTH HISTORY

Has your child ever seen by a mental health professional: _____

When: _____ Therapist seen: _____

For what problem(s): _____

List any previous psychological diagnosis (i.e. ADHD, Depression, Learning Disabilities): _____

Has your child ever attempted suicide: _____ When: _____ How: _____

Has any immediate or extended family ever attempted suicide: _____ Committed suicide: _____

Who: _____ When: _____ How: _____

List any family members who have been in therapy and for what reasons: _____

If any immediate or extended family member has been diagnosed with a mental illness, list their relationship to the child and their diagnosis:

Describe any family member who exhibits problematic or odd behaviors: _____

List any family members who have presently or in the past abused drugs or alcohol: _____

Were they treated: _____ Are they presently in recovery: _____

ABUSE HISTORY

To your knowledge, has your child ever been abused: _____

Physically: _____ Sexually: _____ By whom: _____ When: _____

What was don't to the abuser: _____

To your knowledge, is your child sexually active: _____

LEGAL ISSUES:

Has your child ever been in trouble with the law: _____

What occurred: _____

Age of child at time of event: _____

Has your child ever been in juvenile court (state reason and outcome): _____

EDUCATIONAL HISTORY

Is your child in any special classes: _____ What type: _____

What grade were those classes begun: _____ Is your child in a POD classroom: _____

Describe any difficulties your child has had during his/her schooling or adjusting to school: _____

Have there been any traumatic events that have happened to your child while at school (if yes, describe): _____

How many days has your child been absent this year: _____ Reason: _____

Has there ever been a time when he/she missed a great deal of school (if yes, explain): _____

Describe any academic difficulties (give details): _____

Has your child ever been evaluated for a learning disability, ADHD, or gifted: _____

When: _____ By whom: _____ Results: _____

Has your child ever been retained in any grade (if yes, what grade & reason) _____

What are your child's typical grades (circle one):

A&B

B&C

C&D

D&F

F

Describe any changes in your child's academic performances in the last year or two: _____

SOCIAL HISTORY

Describe how your child interacts with other children: _____

How many friends does he/she play with: _____

Are his/her friends mainly: (circle one):

Same age

Older

Younger

Describe activities he/she enjoys doing: _____

WHO REFERRED YOU TO THIS OFFICE: _____

Below is a list of items that describe children. As you read each item, please decide whether it has been true of your child at any time during the past few months. Then circle the number that best describes your child.

0=not at all	1=just a little	2=quite a bit	3=very much
Always on the go	0 1 2 3	Cruel to animals	0 1 2 3
Can't concentrate long	0 1 2 3	Destroys own things	0 1 2 3
Acts confused (in a fog)	0 1 2 3	Runs away from home	0 1 2 3
Acts without thinking	0 1 2 3	Steals at home	0 1 2 3
Doesn't like books	0 1 2 3	Cusses or talks dirty	0 1 2 3
Moods change quickly	0 1 2 3	Refuses to go to school	0 1 2 3
Shows off or clowns	0 1 2 3	Sets fires	0 1 2 3
Stares or daydreams	0 1 2 3	Steals away from home	0 1 2 3
Talks too much	0 1 2 3	Drinks alcohol	0 1 2 3
Squirms or fidgets	0 1 2 3	Skips school/truant	0 1 2 3
Gets overly excited	0 1 2 3	Uses tobacco	0 1 2 3
Takes dangerous chances	0 1 2 3	Abuses drugs	0 1 2 3
Needs constant watching	0 1 2 3	Lack of bowel control/soils	0 1 2 3
Overactive	0 1 2 3	Deliberately hurts self	0 1 2 3
Keeps at you forever	0 1 2 3	Twitching or jerking	0 1 2 3
Bites fingers or nails	0 1 2 3	Plays with self sexually	0 1 2 3
Afraid of many things	0 1 2 3	Says strange things	0 1 2 3
Feels worthless/inferior	0 1 2 3	Shows little affection	0 1 2 3
Gets teased a lot	0 1 2 3	Speech is unclear	0 1 2 3
Irritable	0 1 2 3	Acts seductively	0 1 2 3
Lacks self-confidence	0 1 2 3	Wets self during day	0 1 2 3
Looks very unhappy	0 1 2 3	Acts like opposite sex	0 1 2 3
Nightmares	0 1 2 3	Wishes to be younger	0 1 2 3
Not liked by children	0 1 2 3	Wishes to be older	0 1 2 3
Not interested in much	0 1 2 3	Feels unliked by others	0 1 2 3
Prefers to be alone	0 1 2 3	Accident prone	0 1 2 3
Wants everything just so	0 1 2 3	Trouble making friends	0 1 2 3
Acts shy or timid	0 1 2 3	Sex play with others	0 1 2 3
Worries about sickness	0 1 2 3	Wets the bed	0 1 2 3
Too fearful or anxious	0 1 2 3	Wishes to be opposite sex	0 1 2 3
Looks sad or depressed	0 1 2 3	Acts like much younger	0 1 2 3
Talks of killing self	0 1 2 3	Acts like much older	0 1 2 3
Too neat and clean	0 1 2 3	Acts overly modest	0 1 2 3
Slow moving/low energy	0 1 2 3	Acts disrespectful	0 1 2 3
Whines a lot	0 1 2 3	Argues	0 1 2 3
Cries easily	0 1 2 3	Bossy	0 1 2 3
Feelings easily hurt	0 1 2 3	Bullies or acts mean	0 1 2 3
Highstrung, tense	0 1 2 3	Defiant	0 1 2 3
No interest in children	0 1 2 3	Demanding own way	0 1 2 3
Eats too much	0 1 2 3	Hits others	0 1 2 3
Withdrawn/uninvolved	0 1 2 3	Tells lies	0 1 2 3
		Punishment doesn't help	0 1 2 3

Signature of person(s) completing form

Relationship/Title