Social History Form

Child's Name: ______________________________ Date: ______________

Address: ____

Date of Birth: __________ Phone: ______________ Gender: ☐ M ☐ F

Person Answering Questions: ______________________________

Relationship to Child: ______________________________

Presenting Concern

What is this child's presenting concern? ______________________________

____

What steps have been taken at home to address this concern? ______________________

____

What are your expectations as to the educational response to this concern? ______________

____

Parents

Mother's Name: ______________________________

Occupation: ______________________ Employer: ______________________

How long with present employer? ______________________________

Father's Name: ______________________________

Occupation: ______________________ Employer: ______________________

How long with present employer? ______________________________

Does this child have other parent(s)/stepparent(s)?
If yes, please provide the following information.

Name: ______________________________ Relationship to Child: ______________

Occupation: ___________________________ Employer: ____________________

How long with present employer? ____

Name: ______________________________ Relationship to Child: ______________

Occupation: ___________________________ Employer: ____________________

How long with present employer? ____

Has this child ever experienced any parental separations, divorces or death?......... No Yes

If yes, when? ________________ How old was the child at the time? __________

Please describe the circumstances. ______________________________________

____

If parents are separated or divorced, who has custody of this child? ____________________

How often does the other parent see this child? (check one) [ ] weekly or more often

[ ] Once or twice a month [ ] Few times a year [ ] Never

Brothers/Sisters

Please list all brothers, sisters, and any other children living with the family.

Age	Sex	Name	Relationship to this Child	Living at home?

How does this child get along with brother(s) and/or sister(s)? ____________________

____

Check any family crises or changes that have occurred in the child's household:

[ ] Death of a family member
[ ] Death of a pet
[ ] Birth of a sibling
[ ] Addiction of family member
[ ] Parent's new job
[ ] Move to a new home
[ ] Serious illness of family member
[ ] Other

Please describe the circumstances: ______________________________

____

____

Family Health

Have any family members had any of the following? If yes, please specify family member's relationship to this child. If child is not living with biological parents, please include health information on biological parents if known.

[ ] Cancer ______________________________
[ ] Diabetes ______________________________
[ ] Kidney Disease ______________________________
[ ] Tourette's Disorder ______________________________
[ ] Seizures or epilepsy ______________________________
[ ] Birth Defect ______________________________
[ ] Alcohol/Drug Abuse ______________________________
[ ] Behavior Disorder ______________________________
[ ] Emotional disturbance ______________________________
[ ] Anxiety ______________________________
[ ] Visual Problems ______________________________
[ ] Hearing Problems ______________________________
[ ] Speech or Language Problems ______________________________
[ ] Learning Disability ______________________________
[ ] Mental Illness ______________________________
[ ] Cystic Fibrosis ______________________________

Pregnancy

Was the mother under a doctor's care? No Yes

Number of previous pregnancies/miscarriages: ___

During the pregnancy, did the mother use: ______ tobacco ______ alcohol ______ drugs

During the pregnancy did the mother experience any problems with (check all that apply):

[ ] Excessive Bleeding
[ ] Allergies
[ ] Preeclampsia/Toxemia
[ ] Virus Illness
[ ] Rh incompatibility
[ ] Preterm Labor
[ ] Nutritional Problems
[ ] Emotional Problems
[ ] Fluid Retention
[ ] Falls or accidents
[ ] Excessive Weight Gain
[ ] Excessive Weight Loss
[ ] Other ______________________________

Birth

At this child's birth, what was the mother's age? ________ Father's age? ________

Was this child born in a hospital? Yes No Birthplace: ______________________

Length of Pregnancy ____________ weeks Birthweight: _______ lbs ________ oz

Length of Labor ________________ hours Apgar Score ______________________

Delivery: [ ] Premature [ ] Full Term [ ] Overdue

Child's condition at birth: ______________________________

Did the child experience breathing problems at birth? Yes No

Check any of the following complications that occurred during birth:

[ ] Forceps Used
[ ] Breech Birth
[ ] Labor Induced
[ ] Caesarean Delivery
[ ] Incubator
[ ] Supplemental Oxygen
[ ] Other Delivery Complications: Describe ______________________________

____

____

Development

At what age did this child first do the following (please check appropriate response)?

Turn Over	[ ] Early	[ ] On Time	[ ] Late
Sit Alone	[ ] Early	[ ] On Time	[ ] Late
Crawl	[ ] Early	[ ] On Time	[ ] Late
Stand/Walk Alone	[ ] Early	[ ] On Time	[ ] Late
Understand First Words	[ ] Early	[ ] On Time	[ ] Late
Speak First Words	[ ] Early	[ ] On Time	[ ] Late
Speaking in Sentences	[ ] Early	[ ] On Time	[ ] Late
Toilet Training	[ ] Early	[ ] On Time	[ ] Late

Were any of the following present, to an extreme, during the first years of life?

[ ] Did not enjoy coddling [ ] Was not calm being held [ ] Excessive restlessness

[ ] Poor sleeping habits [ ] Frequent headbanging [ ] Unusual # of accidents

If yes to any of the above, please explain: ______________________________

____

____

Has this child experienced any of the following problems?

[ ] Walking difficulty [ ] Under/overweight [ ] Withdrawn behaviors

[ ] Nervous behaviors [ ] Tics/twitches [ ] Aggressive behaviors

[ ] Temper tantrums [ ] Sleeping problems [ ] High activity level

[ ] Somatic complaints [ ] Excessive/unusual fears [ ] Speech difficulties

If yes to any, please provide details (age, severity, etc.): ______________________

____

____

Which hand does this child use for writing or drawing? ______________________

Medical History

Please list any childhood diseases and frequency/severity (colds, chicken pox, ear infections, etc.):

____

____

Has this child had difficulty with:

[ ] Frequent ear infections [ ] Had tubes in ears - If so, age: ________

[ ] Hearing loss - Details: ______________________________

[ ] Vision Problems - Details: ______________________________

[ ] Wears glasses - If so, for what purpose? ______________________________

Has this child experienced any of the following (if yes, please provide details):

[ ] Reoccurring Illness ______________________________

[ ] Chronic Illness ______________________________

[ ] Allergies/Asthma ______________________________

[ ] Prolonged High Fevers ______________________________

[ ] Head Injury ______________________________

[ ] Seizures/Convulsions ______________________________

[ ] Coma/Loss of Consciousness ______________________________

[ ] Ingestion of Non-Food Items ______________________________

[ ] Birthmarks ______________________________

[ ] Accidents ______________________________

[ ] Surgical Procedures ______________________________

[ ] Hospitalizations ______________________________

Child's Physician ______________________________

Is this child currently taking any medication? Yes No

What type? ______________________________ Dosage ____________

For what reason? ______________________________

Personality

Describe your child's personality (i.e. outgoing/shy, talkative/quiet, moody/easygoing):

____

____

In your opinion, how does your child see himself/herself? _______________

____

____

What does this child do with his/her free time (sports, hobbies, TV, other interests):

____

____

What does this child do well? _______________________

____

What things are most difficult for this child? _______________

____

How does this child get along with other children his/her age? _______________

____

Does this child have difficulty making friends or meeting new people? _______________

____

Describe how this child gets along with grown-ups: _______________

____

Does this child exhibit any disciplinary problems, if so, please describe: _______________

____

____

How active is this child? [ ] Minimally active [ ] Average [ ] Very Active

Does this child experience mood swings, if so, please describe: ______________________

____

How does this child respond to frustration? ______________________________

____

Please list any previous professional or community agency contacts and the purpose and outcome of these contacts: ____

____

Educational History

Please indicate whether this child has had any of the following school experiences:

Has been retained a grade in school: No Yes If yes, when and why? __________

____

Has difficulty with reading: No Yes If yes, describe: ______________

____

Has difficulty with math: No Yes If yes, describe: ______________

____

Gets poor grades: No Yes If yes, describe recent performance:

____

Dislikes going to school: No Yes If yes, provide reason: __________

____

Is absent from school frequently: No Yes If yes, why: ______________

____

For Office Use Only

Completion Format: [ ] Questionnaire [ ] Interview Interviewer: ______________