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: _____