

CHILD SOCIAL HISTORY

Child's Name: _____ Today's Date: ___/___/___
 Sex: ___ Male ___ Female Age: _____ Birth Date: ___/___/___
 Legal Guardian(s): _____ Relationship to child: _____
 Primary Address: _____ City: _____ Zip: _____
 School: _____ School District: _____ Grade: _____

FAMILY HISTORY

List all people living in primary residence:

Name	Relationship	Age	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all people living in secondary residence:

Name	Relationship	Age	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does anyone in your child's immediate family have any major medical or mental health concerns? ___ No ___ Yes
 Specify: _____

Marital status of biological or adoptive parents (Circle one):

Never Married Married Separated Divorced Widowed

If separated, divorced, or widowed, how old was your child when this occurred? _____
 If divorced or widowed, is Father remarried? ___ No ___ Yes Child age when remarried: _____
 If divorced or widowed, is Mother remarried? ___ No ___ Yes Child age when remarried: _____
 How would you describe your current marriage: _____
 Previous marriage(s): _____

DEVELOPMENTAL HISTORY

Birth Term: ___ Full ___ Premature (Specify number of weeks, if premature: _____)
 Complications during pregnancy or delivery: ___ No ___ Yes Specify: _____
 Did your child's biological mother consume alcohol or smoke during pregnancy? ___ No ___ Yes Specify: _____
 Did your child have any health problems as an infant? ___ No ___ Yes Specify: _____
 Did your child's mother experience post-partum depression or other post-partum health problems? ___ No ___ Yes
 Specify: _____
 Did your child have any specific developmental delays (e.g., motor, language, etc)? ___ No ___ Yes
 Specify: _____

As a toddler, did your child have any difficulties in the following areas (check all that apply):

Sleeping	___ No ___ Yes	Specify: _____
Feeding	___ No ___ Yes	Specify: _____
Soothing	___ No ___ Yes	Specify: _____
Attention	___ No ___ Yes	Specify: _____
Attachment	___ No ___ Yes	Specify: _____
Sensory Issues	___ No ___ Yes	Specify: _____

GENETIC HISTORY

Please check any **biological** relatives with a history of the following concerns:

Academic difficulties	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
Attention deficits	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
Depression	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
Bipolar	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
Anxiety	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
OCD	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
Anger control problems	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
Substance abuse	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin

PHYSICAL HEALTH

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Current health problems: _____

Medications prescribed: _____

Has your child ever suffered any head injuries? ___ No ___ Yes Specify: _____

Does your child have any eating problems? ___ No ___ Yes Specify: _____

Has your child lost or gained significant weight in the past 6 months? ___ No ___ Yes

Does your child have any sleeping problems? ___ No ___ Yes Specify: _____

How many hours of sleep does your child get per night? _____ Does he seem rested once awake? ___ No ___ Yes

How often, and in what way, does your child engage in sustained physical activity? _____

Has your child consumed alcohol? ___ No ___ Yes Specify: _____

Has your child used illegal drugs or abused prescription drugs? ___ No ___ Yes

If yes, indicate what substances: _____

Has your child ever lived with someone who had a drug or alcohol dependency? ___ No ___ Yes

Specify: _____

MENTAL HEALTH

Has your child ever been diagnosed with a mental health disorder? ___ No ___ Yes

Specify: _____

Has your child ever had psychological testing? ___ No ___ Yes If yes, when: _____

Has he/she ever been hospitalized for emotional or behavioral concerns? ___ No ___ Yes

Specify: _____

Has he/she had prior counseling or psychotherapy? ___ No ___ Yes Specify: _____

Has he/she ever experienced an event that you would describe as traumatic? ___ No ___ Yes

Specify: _____

Has your child ever experienced, specifically, any of the following?:

___ Neglect/Abandonment ___ Verbal/Emotional Abuse ___ Physical Abuse ___ Sexual Abuse

Is he/she currently expressing suicidal thoughts? ___ No ___ Yes Specify: _____

Has he/she expressed suicidal thoughts in the past? ___ No ___ Yes Specify: _____

Has he/she ever attempted to harm him/herself physically? ___ No ___ Yes Specify: _____

Please circle any of the following areas if they are of current concern to you as they relate to your child:

Parenting Academics Social Isolation Bed-wetting Addictions Self-Harming

Depression Worry Fears Anger Irritability Self-Esteem

Shyness Aggression Compulsions Attention Impulsivity Hyperactivity

Appetite Digestive Sleep Headaches Low Energy Other Health

LEGAL HISTORY

Does your child have any legal action now pending? ___ No ___ Yes Specify: _____

Does your child have any history of incarcerations, probations and/or parole? ___ No ___ Yes

Specify: _____

SPIRITUAL HISTORY

Although not required, the following questions would contribute to your therapist's understanding of you and your child as spiritual persons. It is not our intent to impose our doctrinal perspective but to acknowledge that counseling is not value-free and to be sensitive to your beliefs. Feel free to discuss any questions or concerns you may have with your therapist.

1. Are spiritual issues or resources important to you in your child's treatment? If so, briefly describe: _____

2. What, if any, spiritual practices does your family engage in? _____

_____ Religious Affiliation, if any: _____