Family Social History Questionnaire

Client's Name: _____ Date of Birth: _____

Father's Name: _____
Father's Age: _____
Occupation: _____
Employer: _____
Highest Grade Completed: _____

Mother's Name: _____
Mother's Age: _____
Occupation: _____
Employer: _____
Highest Grade Completed: _____

Number of Biological Siblings _____ **Number of Step Siblings _____**

Client presently lives with (circle all that apply):

Both Parents Mother Father Step-Parent Other: _____

Others living in the home:

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

Family History

Please check any of the following that apply to the extended family of each parent and any siblings of the client. Please provide a brief explanation of any checked areas at the bottom of the page.

	Mother's Family	Father's Family	Siblings
Anxiety	_____	_____	_____
Depression	_____	_____	_____
Attention/Concentration Difficulties	_____	_____	_____
Learning Disabilities	_____	_____	_____
Alcohol/Substance Abuse	_____	_____	_____
Other Mental Health Issues	_____	_____	_____
Serious Health Issues	_____	_____	_____

Please Explain:

_____
_____
_____
_____

Developmental Information

Please check any of the following that apply to the client's mother during pregnancy and provide additional comments as appropriate.

_____ Serious Injuries/Falls _____
_____ Excessive Bleeding _____
_____ Emotional Stress _____
_____ Lack of Pre-natal Care _____
_____ Alcohol/Drug/Cigarette Use _____
_____ Complications with Delivery _____

Child was born _____ Early _____ On Time _____ Late. If early or late, how much?
Weight at birth: _____ Length at birth: _____
General health of child at birth: _____

Developmental Milestones	**Early**	**On Time**	**Late**
Walking	_____	_____	_____
Motor Coordination	_____	_____	_____
Talking	_____	_____	_____
Speaking in Sentences	_____	_____	_____
Toilet Training	_____	_____	_____

Has your child experienced any of the following? (Please circle and provide dates and details)

Accidents/ Serious Injuries _____
Severe Illnesses/Hospitalizations _____
Head Injuries _____
Surgery _____
Chronic Pain _____
Seizures or Convulsions _____
Lyme Disease _____
Exposure to lead paint _____
Allergies (Environmental; Food; Drug) _____
Death of person close to child _____
Divorce or Separation of Parents _____
Adoption _____
Other Chronic Illnesses _____
Physical Abuse _____
Emotional Abuse _____
Verbal Abuse _____
Sexual Abuse _____
Neglect _____
Bullying and Harassment _____
Alcohol/Substance Use _____
Suicidal Thoughts/Attempts _____
Aggression/Homicidal Thoughts _____
Access to Firearms or other weapons? **No** **Yes (If yes, details):** _____
Destruction of Property _____
Fire Setting _____
Running Away _____

Name of Child's Physician _____ **Date of last Physical:** _____

This Child's Current State of Health Is (please circle): **Excellent** **Good** **Fair** **Poor**
Please Explain: _____

Current Medications (Please list name and dosages) _____
_____

Does this child have regularly scheduled appointments with:

Dentist	Yes	No	If no, any current dental needs? _____
Eye Doctor	Yes	No	
Other Specialists	Yes	No	If yes, Please explain _____

Has this child ever received mental health services in the past? Yes No
Dates of Treatment: _____ Mental Health Professional's Name _____
Location of Practice: _____
For what issues? _____
Prior Diagnoses (If known) _____

Has this child ever been psychiatrically hospitalized? _____

How does this child sleep?	Heavily	Lightly	Very Restlessly	Normally
	Sleep Walks	Nightmares	Bed Wetting	Snores
Average hours per night	_____	Insomnia		
How is this child's appetite?	Excellent	Good	Fair	Poor	Very Picky
	Bingeing	Purging	Laxative Use		
Meals Per Day?	3+Meals/Day	2 Meals/Day	1 Meal/Day	None	How Long?___

Other relevant health issues: _____
_____
_____
_____

Social Information

How would you describe your child's friendships? (Please circle all the apply)

Makes friends easily	Changes friends often	Has few friends	Has no friends
Has many older friends	Has many younger friends	Fights with friends	Parent's don't like choice of friends

How would you describe your child in comparison to other children of the same age?

Extremely mature	Somewhat mature	Average	Less Mature	Extremely Less Mature

Does your child have any of the following behaviors? (Please circle all that apply)

Short Attention Span	Impulsive Behaviors	Excessive Crying	Temper Tantrums
Stealing	Violent Behavior	Fire-Setting	Holding Breath
Pulling Out Hair	Head Banging	Hurting Self on Purpose	Being Accident Prone
Destroys Property	Unusual Rocking	Urinating/Soiling	Suicidal Thoughts
Excessive Thumb Sucking	Won't Give Up Special Toys	Unusual Sexual Behaviors/Interest	Suicide Attempts

Educational History

How old was your child when s/he started school? _____ What grade is s/he currently completing? _____

Please list the name and town of all the schools your child has attended. (Please include any pre-school, Head Start, educational programs, etc.): _____
_____
_____

Has your child ever repeated a grade? If so, what grade(s)? _____

How did your child feel about going to school when s/he started (Please circle)
Happy Excited Nervous Afraid Refused to go Other: _____

How does your child feel about going to school (Please circle)
Happy Excited Nervous Afraid Refused to go Other: _____

Has your child have any of the following at Elementary/Middle school? (Please circle all that apply)

Behavior Concentration Positive Peer Relationships Conflicted Peer Relationships Socially Isolated
Was a bully Was Bullied Positive Teacher Relationships Conflicted Teacher Relationships
Poor Attendance Poor Grades Organization Other: _____

Has your child have any of the following at High School? (Please circle all that apply)

Behavior Concentration Positive Peer Relationships Conflicted Peer Relationships Socially Isolated
Was a bully Was Bullied Positive Teacher Relationships Conflicted Teacher Relationships
Poor Attendance Poor Grades Organization Other: _____

Does your child receive any special services or accommodations at school?
(Please include information regarding special education, 504 Plans, or gifted and talented programs)

_____
_____
_____

What are your child's areas of interest?

_____
_____
_____

What do you see as your child's strengths?

_____
_____
_____

Please share any other information you feel would be helpful to providing your child with effective psychotherapy services.

_____
_____
_____
_____
_____

IF YOU HAVE ANY QUESTIONS OR WOULD PREFER TO SHARE ANY INFORMATION OR CONCERNS VERBALLY, PLEASE FEEL FREE TO CONTACT ME. THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM. THIS INFORMATINO WILL HELP ME TO PROVIDE EFFECTIVE PSYCHOTHERAPY SERVICES THAT WILL MEET YOUR CHILD'S INDIVIDUAL NEEDS.

Home phone: _____ Okay to leave message? _____

Work phone: _____ Okay to leave message? _____

Cell phone: _____ Okay to leave message? _____

Other contact: _____

Emergency Contact(s) Information: _____

Form completed by _____ Date: _____

Relation to child: _____