**Child/Adolescent Social History**

|  |  |  |
| --- | --- | --- |
| **Client Name** (First, MI, Last)      | **Date of Birth** | **Today’s Date** |
| **Presenting Problem** |
| Why are you seeking treatment today?      |
| How long ago did you begin to be troubled by this problem?      |
| How often do you experience this problem?      |
| When did you first consult a professional (counselor, physician, social worker, etc.)?      |
| **Symptom Checklist**Check All Current Problems |
| **[ ]  Nutritional/Eating Pattern Changes/Disorders** |
|  | As evidenced by:[ ] Self-induced Vomiting[ ] Binge Eating[ ] Use of Laxatives | [ ] Increase in Appetite[ ] Decrease in Appetite[ ] Excessive Exercising | [ ] Weight Gain[ ] Weight Loss[ ] None |
| **[ ]  Pain Management** |
|  | As evidenced by:[ ] Pain Interferes with Activities | [ ] None |  |
| **[ ]  Depressed Mood/Sad** |
|  | As evidenced by:[ ] Loss of Interest in Activities[ ] Empty Feeling[ ] Fatigue/Loss of Energy[ ] Thoughts of Harming Yourself | [ ] Hopelessness[ ] Worthlessness[ ] Trouble Concentrating[ ] None | [ ] Indecisiveness[ ] Recurrent Thoughts of Death[ ] Feeling Sad or Depressed |
| **[ ]  Grief Issues** |
|  | As evidenced by:[ ] Loss of Loved One in Past Year | [ ] Other Loss (Describe)      | [ ] None |

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| --- | --- |
| **Client Name** (First, MI, Last)      | **Date of Birth**      |
| **[ ]  Anxiety** |
|  | As evidenced by:[ ] Excessive Worry[ ] Restlessness[ ] Obsessions[ ] Muscle Tension[ ] None | [ ] Irritability[ ] Compulsions[ ] Difficulty Breathing[ ] Pounding Heart | [ ] Excessive Checking[ ] Strong Fears[ ] Shaking[ ] Excessive Handwashing |
| **[ ]  Traumatic Stress** |
|  | As evidenced by:[ ] Recurrent/Intrusive/Distressing Thoughts/Images[ ] Recurrent Dreams/Nightmares | [ ] Startles Easily[ ] Exposure to Traumatic Event | [ ] None |
| **[ ]  Anger/Aggression** |
|  | As evidenced by:[ ] Threatens/Intimidates Others[ ] Initiates Fights | [ ] Physically Hurts People[ ] Physically Hurts Animals | [ ] Use of Weapons[ ] None |
| **[ ]  Oppositional Behaviors** |
|  | As evidenced by:[ ] Loses Temper[ ] Argues[ ] Deliberately Annoys Others | [ ] Blames Others[ ] Easily Annoyed[ ] Angry and Resentful | [ ] Spiteful/Vindictive[ ] None |
| **[ ]  Inattention** |
|  | As evidenced by:[ ] Difficulty Sustaining Attention[ ] Trouble Finishing Things | [ ] Disorganized[ ] Easily Distracted | [ ] Forgetful[ ] None |
| **[ ]  Impulsivity** |
|  | As evidenced by:[ ] Difficulty Resisting Impulses[ ] None | [ ] Trouble Waiting for Turn | [ ] Frequently Interrupts |
| **[ ]  Disturbed Reality Contact** |
|  | As evidenced by:[ ] Hears Voices Others Don’t Hear | [ ] Seeing Things Others Don’t See | [ ] None |
| **[ ]  Mood Swings/Hyperactivity** |
|  | As evidenced by:[ ] Excessive Movement[ ] Decreased Need for Sleep[ ] None | [ ] Excessive Talking[ ] Irritability | [ ] Rapid or Extreme Changes in Mood[ ] Inflated Self-Esteem |
| **[ ]  Addictive Behaviors** |
|  | As evidenced by:[ ] Gambling[ ] Pornography | [ ] Internet[ ] None | [ ] Shopping |

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| **Client Name** (First, MI, Last)      | **Date of Birth**      |
| **[ ]  Sleep Problems** |
|  | As evidenced by:[ ] Difficulty Falling or Staying Asleep[ ] Excessive Sleepiness | [ ] Sleepwalking[ ] None | [ ] Frequent Nightmares |
| **[ ]  Wetting or Soiling** |
|  | As evidenced by:[ ] Daytime | [ ] Nighttime | [ ] None |
| **[ ]  Stressors** |
|       |
| **[ ]  Other** |
|  | As evidenced by:[ ] Obsessions | [ ] Compulsions | [ ] Other:       |
| **Pertinent Developmental Issues** |
| **Mother’s Pregnancy History** (include prenatal exposure to alcohol, tobacco, and other drugs) |
|  | [ ] No Problems Reported      |
| **Infancy (Ages 0-1)** |
|  | [ ] No Problems Reported      |
| **Preschool (Ages 2-4)** |
|  | [ ] No Problems Reported      |
| **Childhood (Ages 5-12)** |
|  | [ ] No Problems Reported      |
| **Adolescent (Ages 13-17)** |
|  | [ ] No Problems Reported      |

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| **Client Name** (First, MI, Last)      | **Date of Birth**      |
| **Living Situation** |
| **Parent’s Home**[ ] Rent [ ] Own | **\*\*Residential Care/Treatment Facility**[ ] Hospital [ ] Temporary Housing [ ] Residential Care [ ] Nursing Home |
| **\*\*Other** [ ] Friend’s Home [ ] Relative’s/Guardian’s Home [ ] Foster Care Home [ ] Respite Care [ ] Homeless Living with Friend [ ] Homeless in Shelter/No Residence [ ] Jail/Prison [ ] Other:       |
| **\*\*Identify Facility or Person’s Name**      |
| **Primary Household** |
| Household Member Names | RelationshipTo Client | Age | Occupation/School | Level ofEducation | Quality of Relationship (Staff Use Only) |
|       |       |     |       |       |       |
|       |       |     |       |       |       |
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| **Secondary Household** |
| **Does client live in more than one household?** [ ] No If no, skip to “Additional Family Members” [ ] Yes If yes, complete the secondary household information below |
| Household Member Names | RelationshipTo Client | Age | Occupation/School | Level ofEducation | Quality of Relationship (Staff Use Only) |
|       |       |     |       |       |       |
|       |       |     |       |       |       |
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|       |       |     |       |       |       |
| **Secondary Household Street Address** (if different from client’s address listed on Demographic Information Form)      |
| **Family Members Who Live in Both Households** [ ] Client only [ ] Client and (List):            |
| **Additional Family Members** (i.e., parents or siblings not living in primary or secondary households) [ ] No parents or siblings other than those listed in primary or secondary households      |
| **Custody and Parenting Plan** [ ] Lives with both parents (biological or adoptive) in same household or with widowed parent [ ] Other (describe):       |

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| **Client Name** (First, MI, Last)      | **Date of Birth**      |
| **Family Environment/Relationships** |
| **Parent-Child (Client) Relationship(s):** [ ] Not Applicable P = Primary Household S = Secondary Household B = Both |
| **Comment on Parent-Child Relationship(s):** (could include parent-child conflict, parent supervision and monitoring of child, cooperation between parents regarding child rearing, parent positive activities with child, parent satisfaction with relationship, child satisfaction with relationship(s))      |
| **Sibling-Child (Client) Relationship(s):** [ ] No Siblings P = Primary Household S = Secondary Household B = Both |
| **Comment on Sibling-Child Relationship(s):** (could include sibling-child conflict, positive activities with child, sibling satisfaction with relationship, child satisfaction with relationship(s))      |
| **Parent Marital or Couples Relationship(s):** [ ] Not Applicable at this time P = Primary Household S = Secondary Household B = Both |
| **Comment on Parent Marital or Couples Relationship(s):** (could include marital or couples conflict, marital or couples satisfaction with relationship(s))      |
| **Family Concerns** |
|  | **If yes, indicate relationship to child:** |
| Family Member Alcohol Abuse: [ ] No [ ] Yes |       |
| Family Member Drug Abuse: [ ] No [ ] Yes |       |
| Family Member Mental Health Problems: [ ] No [ ] Yes |       |
| Family Member Health Problems: [ ] No [ ] Yes |       |
| Family Member Disability: [ ] No [ ] Yes |       |
| Family Member Legal Issues: [ ] No [ ] Yes |       |
| Family Member Financial Concerns [ ] No [ ] Yes |       |
|  |
| **Other** (describe)      |
| **Comment on other family concerns and information relating to financial status** (specify problems that impact client’s needs)      |

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| **Client Name** (First, MI, Last)      | **Date of Birth**      |
| **School Functioning** |
| **Educational Classification** |
| Name of School:       | Current Grade:       |
| Regular Education Classification, No Special Services [ ] Yes [ ] No If no, check all that apply [ ] 01 Multiple disabilities (not deaf-blind) [ ] 06 Orthopedic Impairment [ ] 11 Autism [ ] 02 Deaf-Blindness [ ] 07 Emotional Disturbance (SBH) [ ] 12 Traumatic Brain Injury [ ] 03 Deafness (hearing impairment) [ ] 08 Mental Retardation (DH) [ ] 13 Other Health Impaired (Major) [ ] 04 Visual Impairment [ ] 09 Specific Learning Disability [ ] 14 Other Health Impaired (Minor) [ ] 05 Speech or Language Impairment [ ] 10 Preschoolers with a Disability [ ] 15 Current 504 Plan [ ] Other:       |
| **Comments on Educational Classification/Placement** (please indicate if client is home schooled, in gifted program, etc.)      |
| **Grades** |
| **School Proficiency/Achievement Exams/Ohio Graduation Tests (OGT)****Most Recent Exams:** Grade level taken       [ ] OGT (reading and math only) [ ] Has not taken these exams |
| **Exams Taken** | **Results** |
| **Reading** | [ ] Passed [ ] Did Not Pass [ ] Unknown |
| **Math** | [ ] Passed [ ] Did Not Pass [ ] Unknown |
| **Citizenship** | [ ] Passed [ ] Did Not Pass [ ] Unknown or N/A |
| **Science** | [ ] Passed [ ] Did Not Pass [ ] Unknown or N/A |
| **Writing** | [ ] Passed [ ] Did Not Pass [ ] Unknown or N/A |
| **Other Test Results** (IQ, Achievement, Developmental)  [ ] No other test results reported      |
| **Attendance**  [ ] Not a problem      |
| **Previous Grade Retentions** [ ] None reported      |

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| **Client Name** (First, MI, Last)      | **Date of Birth**      |
| **Suspensions/Expulsions** [ ] None reported      |
| **Other Academic School Concerns** (including performance/behavioral problems due to AOD use) [ ] None reported      |
| **Barriers to Learning** [ ] None reported [ ] Inability to Read or Write [ ] Other:      |
| **Peer Relationships/Social Functioning**      |
| **Special Communication Needs** [ ] None reported [ ] TDD/TTY Device [ ] Sign Language Interpreter [ ] Assistive Listening Device(s) [ ] Language Interpreter Services Needed/Other Spoken Language:        [ ] Other:        |
| **Employment** |
| [ ] Not Pertinent – Skip this section |
| **Currently Employed?** [ ] Yes [ ] No If yes, name of employer |
| Name of Employer:       Job Title:       |
| **Employment Interests/Skills/Concerns**      |

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| **Client Name** (First, MI, Last)      | **Date of Birth**      |
| **Legal History** |
| **Current Legal Status** [ ] None Reported [ ] On Probation [ ] Detention [ ] On Parole [ ] AoD Related Legal Problems [ ] Awaiting Charge [ ] Court Ordered to Treatment [ ] Others |
| **History of Legal Charges**  [ ] No [ ] Yes If yes, check and describe      | [ ] Status Offense (e.g., Unruly)[ ] Delinquency |
| **Name of Probation/Parole Officer** (if applicable)      |
| **Adjudications** [ ] No [ ] Yes If yes, describe:        |
| **Detentions or Incarcerations** [ ] No [ ] Yes If yes, describe:        |
| **Civil Proceedings** [ ] No [ ] Yes If yes, describe:        |
| **Domestic Relations Court Involvement** [ ] No [ ] Yes If yes, describe:        |
| **Juvenile Court Involvement (**related to child abuse, neglect, or dependency)Current: [ ] No [ ] Yes Comment:       Past: [ ] No [ ] Yes Comment:        | **Caseworker Name** (if applicable)      |
| **Children’s Protective Services Involvement with Family** [ ] No [ ] Yes If yes, describe:       |
| **Name of Children’s Protective Services Caseworker(s) Assigned to Family** (if applicable) [ ] None Reported |
| **Name of Guardian ad Litem (GAL) or Court Appointed Special Advocate (CASA) Assigned to Family** (if applicable) [ ] None Reported |

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| **Client Name** (First, MI, Last)      | **Staff Use Only: Client Number**      | **Date of Birth**      |
| **Child/Adolescent Health History Questionnaire**This form should be completed as fully as possible by client, but reviewed by medical or clinical staff |
| Has the child had any of the following health problems? |
|  | Now | Past | Never | What Treatment Was Received and Date(s) |
| Anemia |       |       |       |       |
| Arthritis |       |       |       |       |
| Asthma |       |       |       |       |
| Bleeding Disorder |       |       |       |       |
| Blood Pressure (high or low) |       |       |       |       |
| Bone/Joint Problems |       |       |       |       |
| Cancer |       |       |       |       |
| Cirrhosis/Liver Disease |       |       |       |       |
| Diabetes |       |       |       |       |
| Epilepsy/Seizures |       |       |       |       |
| Eye Disease/Blindness |       |       |       |       |
| Fibromyalgia/Muscle Pain |       |       |       |       |
| Glaucoma |       |       |       |       |
| Headaches |       |       |       |       |
| Head Injury/Brain Tumor |       |       |       |       |
| Hearing Problems/Deafness |       |       |       |       |
| Heart Disease |       |       |       |       |
| Hepatitis/Jaundice |       |       |       |       |
| Kidney Disease |       |       |       |       |
| Lung Disease |       |       |       |       |
| Menstrual Pain |       |       |       |       |
| Oral Health/Dental |       |       |       |       |
| Stomach/Bowel Problems |       |       |       |       |
| Stroke |       |       |       |       |
| Thyroid |       |       |       |       |
| Tuberculosis |       |       |       |       |
| AIDS/HIV |       |       |       |       |
| Sexually Transmitted Disease |       |       |       |       |
| Learning Problems |       |       |       |       |
| Speech Problems |       |       |       |       |
| Anxiety |       |       |       |       |
| Bipolar Disorder |       |       |       |       |
| Depression |       |       |       |       |
| Eating Disorder |       |       |       |       |
| Hyperactivity/ADD |       |       |       |       |
| Schizophrenia |       |       |       |       |
| Sexual Problems |       |       |       |       |
| Sleep Disorder |       |       |       |       |
| Suicide Attempts/Thoughts |       |       |       |       |
| Other:       |       |       |       |       |
| Other:       |       |       |       |       |
| **Please note family history of any of the above conditions and client’s relationship to that family member** |

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| **Client Name** (First, MI, Last)      | **Date of Birth**      |
| **Current Medication Information** (medical and psychiatric prescription/OTC/herbal) |
|  [ ] None Reported |
| **Medication** | **Rationale** | **Dosage/Route/Frequency** | **Staff Use Only: Compliance** |
|  |  |  | Yes | No | Partial | Unk |
|       |       |       |     |     |     |     |
|       |       |       |     |     |     |     |
|       |       |       |     |     |     |     |
|       |       |       |     |     |     |     |
|       |       |       |     |     |     |     |
|       |       |       |     |     |     |     |
| **Primary Care Physician** (name, phone no., and address)      | **Date of Last Physical Exam**      |
| **Other Prescribing Physician(s)** (name, phone no., and address)      |
| **Past Psychiatric Medications** |
|  [ ] None Reported |
| **Past Psychiatric Medications** | **Reason for Stopping** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
| **Has the child had medical hospitalization/surgical procedures in the last 3 years?** [ ] No [ ] Yes If yes, complete information below |
| **Hospital** | **City** | **Date** | **Reason** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| **Allergies/Drug Sensitivities** [ ] None [ ] Food (specify)       [ ] Medicine (specify)       [ ] Other (specify)       |
| **Pregnancy History** [ ] Not Pertinent |
| **Currently Pregnant?** (If yes, expected delivery date)[ ] No [ ] Yes Expected Delivery Date       | **Receiving Prenatal Healthcare?** (If yes, indicate provider)[ ] No [ ] Yes Provider       |
| **Currently Breastfeeding?** [ ] No [ ] Yes |
| **Last Menstrual Period Date**      | **Any Significant Pregnancy History?** (if yes, explain)[ ] No [ ] Yes       |

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| **Client Name** (First, MI, Last)      | **Date of Birth**      |
| **Medical Information** |
| **Last Physical Examination**By Whom:       Date:       Phone No.(if known):       |
| **Indicate how many times in the past 12 months the child has used these medical services:** Hospital admissions Emergency room visits Regular visits to doctor Regular visits to dentist |
| **Has the child had any of the following symptoms in the past 60 days?** (please check all that apply) |
| [ ] Ankle Swelling | [ ] Diarrhea | [ ] Nervousness | [ ] Tingling in Arms and/or Legs |
| [ ] Bed wetting | [ ] Dizziness | [ ] Nosebleeds | [ ] Tremor |
| [ ] Blood in Stool | [ ] Falling | [ ] Numbness | [ ] Urination Difficulty |
| [ ] Breathing Difficulty | [ ] Gait Unsteadiness | [ ] Panic Attacks | [ ] Vaginal Discharge |
| [ ] Chest Pain | [ ] Hair Change | [ ] Penile Discharge | [ ] Vision Changes |
| [ ] Confusion | [ ] Hearing Loss | [ ] Pulse Irregularity | [ ] Vomiting |
| [ ] Consciousness Loss | [ ] Lightheadedness | [ ] Seizures | [ ] Other:       |
| [ ] Constipation | [ ] Memory Problems | [ ] Shakiness |       |
| [ ] Coughing | [ ] Mole/Wart Changes | [ ] Sleep Problems | [ ] Other:       |
| [ ] Cramps | [ ] Muscle Weakness | [ ] Sweats (night) |       |
| **Immunizations – Has the child had or been immunized for the following diseases?** (please check all that apply) |
| [ ] Chicken Pox[ ] Mumps | [ ] Diphtheria[ ] Polio | [ ] German Measles[ ] Small Pox | [ ] Hepatitis B[ ] Tetanus | [ ] Measles[ ] Other:       |
| **Immunizations Within the Past Year**      |
| **Height**      | **Has client’s weight changed in the past year?**[ ] No [ ] Yes If yes, by how much (+ or -):       |
| **Weight**      |  |
| **Nutritional Screening** |
| **No Problem**[ ]  | **Eating**[ ] More [ ] Less [ ] Not Eating | **Drinking**[ ] More [ ] Less [ ] Takes Liquids Only | **Appetite**[ ] Increased [ ] Decreased |
|   [ ] Nausea [ ] Vomiting [ ] Trouble Chewing or Swallowing |
| **Special Diet**      | **Other**      |

|  |  |
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| **Client Name** (First, MI, Last)      | **Date of Birth**      |
| **Pain Screening** |
| **Does pain currently interfere with the child’s activities?** (if yes, how much does it interfere with these activities [please check]) [ ] No [ ] Yes [ ] Not at all [ ] Mildly [ ] Moderately [ ] Severely [ ] Extremely |
| **Please indicate the source of the pain**      |
| **Substance Use History/Current Use**(Please check and complete appropriate columns) |
| **Which of the following has the child used?** | **Age first used** | **Age last used** | **Frequency of use** |
|  [ ] Beer |       |       |       |
|  [ ] Wine |       |       |       |
|  [ ] Liquor |       |       |       |
|  [ ] Heroin |       |       |       |
|  [ ] Barbiturates |       |       |       |
|  [ ] Amphetamines |       |       |       |
|  [ ] Crack |       |       |       |
|  [ ] Cocaine |       |       |       |
|  [ ] Marijuana/Hashish |       |       |       |
|  [ ] LSD |       |       |       |
|  [ ] Inhalants |       |       |       |
|  [ ] PCP |       |       |       |
|  [ ] MDMA (XTC) |       |       |       |
|  [ ] Prescription drugs off the street |       |       |       |
|  [ ] Non-prescription drugs by injection |       |       |       |
|  [ ] Other |       |       |       |
| **Caffeine** | **Nicotine** |
|        Cups of caffeinated coffee per day |       Packs of cigarettes per day |
|        Cups of caffeinated tea per day |       Other nicotine products per day |
|        Cups of caffeinated soft drinks per day |       Other Use:       |
|        Ounces of chocolate per day |  |
| **Print Name of Person Completing This Questionnaire**      | **Signature of Person Completing This Questionnaire** | **Date**      |
| **Clinician Reviewer Comment** (if any) [ ] Medical Review Needed      |
| **Print Name of Clinician**      | **Signature of Clinician** | **Date**      |

|  |  |
| --- | --- |
| **Client Name** (First, MI, Last)      | **Date of Birth**      |
| **This Page For Office Use Only****Comments, Recommendations or Referrals by Medical Reviewer**Check Referral(s) Needed and Specify Action(s) |
| [ ] No Referral Needed[ ] Primary Care Physician:      [ ] Healthcare Agency:      [ ] Specialty Care:      [ ] Other (specify):       |
| **Recommendations shared with client?**[ ] No [ ] Yes If yes, client’s response:       |
| **If no, how will recommendations be shared with client?**            |
| **Medical Reviewer Signature/Credentials** (Nurse, PA, NP, MD, DO) | **Date** |
| **Client Signature** | **Date** |
| **Clinician Reviewing** | **Date** |