Your Family Clinic
206 Central Avenue 514 Old Richton Rd.
Petal, MS 39465

Abbreviated Social History
Child and Adolescent

601-408-7203 601-544-8935

Instructions: It is very important that you anser all the items as completely and as detailed as possible. If you do not know the answer to a question just put a question mark (?). If the question does not apply to your child, just put NA for not appropriate. Your help on this is much appreciated.

Child's name: _____ Age: _____
Mother's name:_____Birth Father's name:_____
Child's school: _____ Current Grade in School _____
Current or last grades on report card _____
Brother's names and ages _____
Sister's names and ages _____

In 3 or 4 sentences what do you feel is your child's present problems?

When did the problem(s) begin or when did you first notice a change in your child's behavior?_____
What promoted you to seek help at this time?

Has your child received previous psychiatric, psychological, counseling services or been hospitalized for emotional/behavioral problems? _____ If yes, how many therapists/institutions?_____

Institution or Therapist Name	Dates of Service	Was it effective (circle)?
_____	_____	Yes or No
_____	_____	Yes or No
_____	_____	Yes or No
_____	_____	Yes or No
_____	_____	Yes or No

Current Symptoms

Please circle any of the following that apply to your child now and indicate for how long it has been a problem (problem is defined as more than other children his/her age) **(Please note: yrs= years; mo = months)**:

poor attention span ____ yrs ____mo

hyperactivity ____ yrs ____mo

easily distracted ____ yrs ____mo

restless ____ yrs ____mo

difficulty going to sleep ____ yrs ____mo

difficulty staying asleep ____ yrs ____mo

difficulty awakening ____ yrs ____mo

bed wetting ____ yrs ____mo

day time wetting ____ yrs ____mo

soiling pants ____ yrs ____mo

temper tantrums ____ yrs ____mo

temper tantrums that lasted
longer than 15 minutes ____ yrs ____mo

aggressive ____ yrs ____mo

fighting ____ yrs ____mo

poor social skills ____ yrs ____mo

destructive ____ yrs ____mo

lying ____ yrs ____mo

suspensions from school ____ yrs ____mo

trouble reading ____ yrs ____mo

poor hand writing ____ yrs ____mo

stealing ____ yrs ____mo

drug/alcohol use ____ yrs ____mo

cigarettes ____ yrs ____mo

sadness ____ yrs ____mo

fears ____ yrs ____mo

anxiety ____ yrs ____mo

crying ____ yrs ____mo

worries ____ yrs ____mo

irritable ____ yrs ____mo

defiant ____ yrs ____mo

talks back to adults ____ yrs ____mo

seeing things that are not there ____ yrs ____mo

hearing things that are not there ____ yrs ____mo

nightmares ____ yrs ____mo

repetitive behaviors ____ yrs ____mo

compulsive behaviors ____ yrs ____mo

motor or vocal tics ____ yrs ____mo

shoplifting ____ yrs ____mo

trouble learning math ____ yrs ____mo

frequent headaches ____ yrs ____mo

Developmental History

Pregnancy and Birth: If adopted, indicate at what age ____ If adopted, were the natural parents a relative? ____
Parent's ages when child was born: Mom_____ Dad_____ Was your child placed on oxygen when he/she was born (circle)? Yes No
Was the mother free of emotional strain during the pregnancy? _____ if no, what? _____
Did either parent use alcohol or drugs before the pregnancy? _____ if yes, whom? _____

Please list any concerns or problems with your child's birth:

Who was the primary caretaker during infancy? _____ if other than mother, for how many years? _____
Was the child during the first year: irritable ___ fussy ___ listless ___ normally active __ very active __ quiet __
Did the baby ever experience colic? ____, experience stomach aches? _____ excessive vomiting? _____
Did the baby receive all the immunizations? ____
Were there ever any problem after an immunization? ____ if yes, what _____
Did the mother breast feed the baby? ____ if yes, for how long _____ if no, did the formula have to change ___
Does or did your child ever snore? ___ at what age and for how long _____

Please list any concerns ro problems with your child's development (e.g., were all the developmental milestones met at normal ages? Was speech developed normally? Any problems in sleep patterns?):

Trauma

Please describe any incidents of sexual, physical or emotional abuse.

Has your child ever been sexually inappropriate? ____ if yes, please describe:

Has there ever been any domestic violence or spouse abuse while your child has been alive? ____ if yes, please describe:

Has your child lost a significant family member or friend? _____ if yes, please describe:

Family History

Parental History:
Current marital status of primary caretaker _____ How many times have you been married? _____
If currently married, how long have you been married? _____ How is the marriage? _____
Have any of the child's parents been divorced? _____ if yes, who? _____ How old was the child when the divorce occurred? _____ How often does the child see the non custodial parent? _____

If currently married, please describe the current marriage relationship by circling the following that apply:

verbal arguments	physical violence	name calling	lack of respect
excessive work	affairs	lack of time together	parenting disagreements
love	kindness	respect	displays of affection
quality time together	common interests	fun	other _____

Describe both parents education:

Work history:

Parents' interest, hobbies, and activities:

Please describe any parent's problems in health, emotional functioning, legal, substance use, or financial:

Relationships

Please describe the history and quality of the child's relationship with his or her:

Mother:

Birth Father:

Step Father (if any):

sibling(s) and extended family:

friends:

Mother's current place of employment and # of hours work per week _____
Father's current place of employment and # of hours work per week _____
Caretaker's (if other than mother) place of employment and # of hours _____
Step parent (if appropriate) place of employment and # of hours _____
Does any other child in the family have behavior, academic, or emotional problems? _____ if yes, please describe:

Current Medical Information

Name of Child's Physician? _____ When was the last visit? _____
Medications your child is currently taking _____
Medications your child has taken in the past _____

Please indicate (if any) your child's current health problems:

Medical History

Has your child ever been hospitalized?____ if yes, for what _ _____
Has your child ever had a fever of a 104 or above? ___ if yes, when _____
Has your child had normal urination? ____ Has your child's hearing been checked? _____ Eyesight checked?___
Has your child had a physical recently?____ Any problems?___ if yes, what _____
Please circle any of the following that your child has had and indicate your child's age (or ages) at the time:

measles (age ____)	mumps (age ____)	knocked unconscious (age ____)
chicken pox (age ____)	whooping cough (age ____)	drug reactions (age ____) _____
pneumonia (age ____)	motor tic (age ____)	spider bite (age ____)
asthma (age ____)	seasonal allergies (age ____)	operations (age ____) _____
roseola (age ____)	tonsillectomy (age ____)	head injury (age ____) _____
convulsions (age ____)	seizures (age ____)	accidents or falls (age ____) _____
headaches (age ____)	bronchitis (age ____)	broken bones (age ____)_____
eczema (age ____)	psoriasis (age ____)	other skin problems (age ____) _____
white coating on tongue (age ____)	fissures or cuts in tongue (age ____)	white spots on finger nails (age ____)

Please list any other medical history not covered above:

Is the child's mother on any medication (circle)? Yes No If yes, please list the medications:

Is the child's father on any medication (circle)? Yes No If yes, please list the medications:

Please describe any previous or current psychological treatments for either of the parents including any history of psycho-tropic medication:

Please indicate which family members have experience any of the following. Please include and indicate parents (m for mother, f for father), step father (sf), step mother (sm), siblings (s), maternal grandparents (mgf, mgm), paternal grandparents (pgf, pgm), current caretaker (cc), maternal aunts (ma), maternal uncles (mu), paternal aunts (pa), paternal uncles (pu), maternal cousin (mc), and paternal cousin (pc):

anxiety _____ depression _____ anger control _____

bipolar disorder _____ mood swings _____ compulsive behaviors _____

panic attacks _____ irritability _____ aggression _____

sexual abusing others _____ physically abusing others _____ neglecting others _____

sexual abuse victim _____ physical abuse victim _____ neglected _____

mental problems _____ hospitalized for emotions _____ sleep problems _____

stealing _____ lying _____ setting fires _____

juvenile sentences _____ arrested _____ jail or prison time _____

destruction _____ impulsivity _____ hyperactive _____

inattentive _____ learning problems _____ sleeps too much _____

went to college _____ dropped out of high school _____ has lots of money _____

mentally retarded _____ high blood pressure _____ fatigue _____

drug use _____ excessive alcohol use _____ special education _____

running away _____ extra marital affairs _____ severe trauma _____

counseling _____ psychosis (hallucinations) _____ seizures _____

headaches _____ personality problems _____ bed wetting _____

School History

Has your child ever been placed in special education? ___ if yes, what for what subjects _____
Has your child ever failed or repeated a grade? ___ if yes, what grades _____
Has your child ever done well on a subject and then do consistently poorly? _____ if yes, what subject? _____
How well does your child read? _____ do math? _____ spell? _____ comprehend? _____
Has your child ever had discipline problems in school? ____ if yes, what grades _____
Who took your child to school for the first day of school? _____ What was child's reaction? _____
Has your child ever had psycho-educational testing? ___ if yes, when, by whom and for what purpose?: _____

Please list any other concerns you may have about your child's education and interaction with teachers, peers and authority figures:

Child's Substance Use (if appropriate)

Have you suspected your child uses any of the following? If so, please circle and indicate if you think it is a big problem (bp), moderate problem (mp) or not a problem (np).

cigarette smoking _____	chewing tobacco _____	energy drinks _____
caffeine pills _____	alcohol _____	inhalants (gas, glue) _____
marijuana (pot, THC, hashish) _____	amphetamines (speed, diet pills) _____	
cocaine _____	crack _____	opiates (heroin) _____
pain pills _____	misuse of Ritalin _____	prescriptions _____
ecstacy _____	spice _____	LSD _____
mushrooms _____	other _____	

Home Behavior Management

Please describe what discipline techniques that you use and please describe their effectiveness:
What do you see your role will be in your child's process of change?

What (if anything) do you or your spouse want to change as parents or persons?

Miscellaneous Information (if appropriate)

Is your child sexually active? ____ if yes, please describe how you know and how long your child has been sexually active:

Does your child attend church? _____ if yes, which church? _____ and please describe their attitude about attending church:

What strengths does your child have? _____

_____

What do you think will be most helpful to your child? Please circle or underline all that apply:

individual therapy, family therapy, medication, testing, marriage counseling, hospitalization, residential treatment, MYPAC services, group home, wilderness course, just someone to talk to, healing from trauma, anger management, help to overcome learning disorders, behavior management, parenting skills for the caretakers, coping skills, relaxation, I have no idea, I trust Dr. Dan Moore's insight, adoption, other (please specify):_____

Please list other information that you feel is relevant: