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**Reevaluation Social History**

Date:School:

ID#: Grade:

*The following information is considered confidential. Please answer all questions as well as you can.*

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| **Identifying Information** |
| Child’s name: |  |
| Date or birth and current age: | DOB: Age:  |
| Gender and race: | Gender: Race:  |
| Person completing form: | Name: Do you have legal custody? Yes No |
| **Family Information** |
| Home address: | Street address: Apt/lot #: City: State: Zip code: County:  |
| Phone number(s) and email address: | Home: Cell:Work: Email address: |
| **Biological Parents or Guardian Information** |
| Parent/GuardianFemale name:Relationship:[ ]  Biological Mother[ ]  Step-Mother[ ]  Adoptive Mother[ ]  Grandmother[ ]  Other relative[ ]  UnrelatedMale name:Relationship:[ ]  Biological Father[ ]  Step-Father[ ]  Adoptive Father[ ]  Grandfather[ ]  Other relative[ ]  Unrelated | Age: Education: Occupation: Work title: Employer: Lives in the home? Yes NoIf not biological mother: Age: Education: Occupation: Work title: Employer: Age: Education: Occupation: Work title: Employer: Lives in the home? Yes NoIf not biological father: Age: Education: Occupation: Work title: Employer:  |
| The child is:  | [ ]  Natural [ ]  Adopted [ ]  Other |
| The child’s parents are: | [ ]  Married [ ]  Divorced [ ]  Separated [ ]  Never married |
| Please list all siblings, including full, half and step-siblings. | Name: Age: Living with child? Yes NoName: Age: Living with child? Yes NoName: Age: Living with child? Yes NoName: Age: Living with child? Yes NoName: Age: Living with child? Yes No |
| Please list anyone else living in the home and relationship to the child. | Name: Relationship: Name: Relationship: Name: Relationship:  |
| Are there any significant stressors or pressures on the family? Explain if yes. |  |
| Primary language spoken by student: |   |
| Other languages spoken in the home: |  |
| **Child/Family Medical History** |
| Date of last physical exam: | [ ]  Less than 6 months ago [ ]  6 – 12 months ago [ ]  1 – 2 yrs ago [ ]  More than 2 yrs ago |
| Any problems with vision or hearing? Explain if yes. | [ ]  No [ ]  Yes:  |
| Has the child ever had problems with recurrent ear infections?Has the child had surgery to place tubes in ears? Give details if yes. | [ ]  No [ ]  Yes: [ ]  No [ ]  Yes:  |
| Describe any head injuries (e.g., date, what happened, changes in behavior after the injury). |  |
| List any hospitalizations or surgeries | [ ]  None List hospitalizations with dates:  |
| Current medications, dosage, and reason: | Medication: Dosage: How often:  Reason:Medication: Dosage: How often:Reason:Medication: Dosage: How often:Reason:Medication: Dosage: How often:Reason: |
| Is your child currently experiencing: | [ ]  Inappropriate/deficient social skills[ ]  Abdominal pains/vomiting[ ]  Headaches[ ]  Sleep difficulties[ ]  Eating difficulties[ ]  Aggression[ ]  Noncompliance at home[ ]  Depressed or sullen mood | [ ]  Impulsivity or hyperactivity [ ]  Temper tantrums[ ]  Anxiety/worry[ ]  Clumsiness[ ]  Self-injurious behavior[ ]  Forgetfulness[ ]  Noncompliance at school[ ]  Suicidal feelings or actions |
| **Social History Update** |
| Check the following behaviors that describe the child: | [ ]  Self-conscious[ ]  Feels inferior[ ]  Short attention span[ ]  Fails to finish tasks[ ]  Argues, quarrels[ ]  Unusual fears[ ]  Daydreams[ ]  Lacks self-confidence[ ]  Brags, boasts[ ]  Distractible | [ ]  Restless [ ]  Impulsive[ ]  Concerned with bodily changes [ ]  Overexcited easily[ ]  Sulks and pouts[ ]  Rapid mood swings [ ]  Overactive [ ]  Listless [ ]  Changeable [ ]  Bullying others [ ]  Being bullied  |
| Check factors affecting family: | [ ]  Blended family problems[ ]  Unemployed[ ]  Divorce/separation[ ]  Frequent moves[ ]  Incarcerations  | [ ]  Parent-child conflict [ ]  Sibling conflict[ ]  Custody problems [ ] Parent conflict |
| Describe significant events of concerns affecting your child: |  |
| Has your child ever had contact with a psychiatrist, psychologist, clinic or private agency? Explain if yes.Has your child ever had an evaluation? | [ ]  No [ ]  Yes: [ ]  Yes [ ]  No Does the school have a copy of the evaluation: [ ]  Yes [ ]  No  |
| Describe the child’s attitude toward school? |  |
| Describe the child’s choice of friends (how many, what age, do they get along well)? |  |
| What are your child’s activities when not in school? |  |
| List your child’s chores and responsibilities at home. |  |
| What are your goals for your child’s future? |  |
| **Consulting Professionals & Other Professionals** |
| Please list all others involved in the child’s care, including physicians, psychologists, social workers, therapists, DCS case workers, or probation officers: | Name/Profession: Nature of their involvement:  |
| **Child’s Strengths/Weaknesses** |
| Please use this space to note the child’s strengths:  |  |
| Please use this space to note the child’s weaknesses:  |  |
| Please use this space to note any additional comments:  |  |
| **Current Preschool Information** |
| Name of preschool attending: |  |
| Child attends school: | [ ]  Full time [ ]  Part timeNumber of days per week: What time of day: |