**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?  |
| **Family Information** |
| Home address: | Street address:  Apt/lot #:  City:  State: IN 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? If not biological mother: Age:  Education:  Occupation: Work title:  Employer: Age:  Education:  Occupation: Work title:  Employer: Lives in the home? If not biological father: Age:  Education:  Occupation: Work title:  Employer:  |
| The child is:  |  [ ]  Natural [ ]  Adopted [ ]  Other |
| The child’ parents are: |  [ ]  Married [ ]  Divorced [ ]  Separated [ ]  Never married |
| Please list all siblings, including full, half and step-siblings. | Name:       Age:       Living with child?      Name:       Age:       Living with child?       Name:       Age:       Living with child?       Name:       Age:       Living with child?      Name:       Age:       Living with child?       |
| 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/Additional Comments** |
| 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:  |       |