**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/guardian  Female name:    Relationship:  Biological Mother  Step-Mother  Adoptive Mother  Grandmother  Other relative  Unrelated  Male 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: |  | | |