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MEDICAL SOCIAL HISTORY – CHILD

This form is being completed by: ______________________________

If not client, relationship to client: ______________________________

CLIENT INFORMATION:

Full Name ____________________ Social Security Number ____________________

Address ____________________ Date of Birth, Age, and Place of Birth ____________________

City, State, Zip Code ____________________ Telephone Number ____________________

Ethnicity:

- ☐ (Skip)
- ☐ American Indian
- ☐ Alaskan Native
- ☐ Asian
- ☐ African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White
- ☐ Hispanic
- ☐ Bi-racial
- ☐ Multi-racial
- ☐ Other:_______________

Biological Father?

Name: ______________________________

Occupation: ______________________________

Biological Mother?

Name: ______________________________

Occupation: ______________________________

Number of brothers?______________________________

Number of sisters? ______________________________

Place in birth order (e.g., "second oldest of six children")? ______________________________

Did your child move frequently while growing up?

- ☐ Yes
- ☐ No
- ☐ Don't know

With whom does your child now live?______________________________

How long has your child lived in this area?_____________

Dwelling type?

- ☐ Home
- ☐ Apartment
- ☐ Hotel or motel
- ☐ Shelter
- ☐ Homeless
- ☐ Mobile home
- ☐ Room in a home
- ☐ Other

Are there currently any custody disputes about this child?

- ☐ Yes
- ☐ No
- ☐ Don't know

Do you receive:

- ☐ TANF
- ☐ Welfare
- ☐ Regular Social Security
- ☐ SSI
- ☐ Social Security Disability
- ☐ Medicaid
- ☐ Medicare
- ☐ Food Stamps
- ☐ Alimony
- ☐ Child support
- ☐ Other: Specify: ______________________________________
- ☐ No support received

CHILD DEVELOPMENTAL HISTORY QUESTIONNAIRE

How long were the child's natural parents married until the pregnancy?

- ☐ Less than one year
- ☐ 1 to 3 years
- ☐ Over 3 years
- ☐ Were not married at the time
- ☐ Don't know

Was this a planned pregnancy?

- ☐ Yes
- ☐ No
- ☐ Don't know

How many pregnancies did the mother have before this pregnancy?______________________

How old was the natural mother when this child was born?______________________________

How old was the natural father when the child was born?________________________________

Did the mother have bleeding during the pregnancy?

- ☐ Yes
- ☐ No
- ☐ Don't know

Did the mother have any major illness or medical problems during this pregnancy?

- ☐ Yes
- ☐ No
- ☐ Don't know

What medications did the mother take during the pregnancy?

- ☐ Antibiotics
- ☐ Medications for nerves
- ☐ Medications for depression
- ☐ Other prescription medication
- ☐ Don't know/does not apply

While pregnant, the mother smoked:

- ☐ No cigarettes
- ☐ Less than one pack a day
- ☐ More than one pack a day
- ☐ Don't know

While pregnant, the mother drank:

- ☐ No alcohol
- ☐ Alcohol on an infrequent social basis
- ☐ Alcohol regularly
- ☐ Alcohol heavily

- ☐ Don't know

Did the mother or father use any hard drugs <u>before</u> the pregnancy?

- ☐ Mother
- ☐ Father
- ☐ Mother and father
- ☐ Neither the mother or father
- ☐ Don't know

Did the mother use any hard drugs <u>while</u> pregnant?

- ☐ Yes
- ☐ No
- ☐ Don't know

Complications of this pregnancy included:

- ☐ None
- ☐ Toxemia
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Poor nutrition
- ☐ Poor emotional health
- ☐ Amniocentesis
- ☐ Loss of consciousness in mother
- ☐ Don't know

How was the labor with this child's birth?

- ☐ Easy
- ☐ Normal
- ☐ Hard
- ☐ Don't know

The baby was born:

- ☐ Head first
- ☐ Breach
- ☐ Caesarean
- ☐ Don't know

Was the baby's oxygen supply in danger during the delivery?

- ☐ No
- ☐ Yes
- ☐ Don't know

Was the baby full-term at birth?

- ☐ Yes
- ☐ No
- ☐ Don't know

The baby weighed how many pounds at birth?______________

In the first few months did the baby eat well?

- ☐ Yes
- ☐ No
- ☐ Don't know

In the first few months did the baby sleep well?

- ☐ Yes
- ☐ No
- ☐ Don't know

In the first few months did the baby have breathing problems?

- ☐ Yes
- ☐ No
- ☐ Don't know

The baby was:

- ☐ Cranky
- ☐ Calm
- ☐ Active
- ☐ Shy
- ☐ Hard to please
- ☐ Easy
- ☐ Lazy
- ☐ Difficult
- ☐ Persistent
- ☐ Social
- ☐ Happy
- ☐ Sleepy
- ☐ None of the above
- ☐ Don't know

The baby

- ☐ Liked to be held
- ☐ Cuddled well
- ☐ Rocked self a lot
- ☐ Cried a lot
- ☐ Would not make eye contact
- ☐ Seemed sad
- ☐ Seemed slow to develop
- ☐ None of the above
- ☐ Don't know

Most of the baby's developmental milestones seemed to be:

- ☐ On time
- ☐ Early
- ☐ Late
- ☐ Don't know

The baby walked alone when:

- ☐ Less than 12 months old
- ☐ 12 to 15 months old
- ☐ Older than 15 months
- ☐ Never walked
- ☐ Don't know

The baby started to talk:

- ☐ On time
- ☐ Early
- ☐ Late
- ☐ Don't know

The baby's toilet training began:

- ☐ At less than 1 to 1 ½ years of age
- ☐ Between 1 ½ to 3 years of age
- ☐ Later than 3 years
- ☐ Never trained
- ☐ Don't know

Was toilet training a battle?

- ☐ Yes
- ☐ No
- ☐ Don't know

Are there current elimination problems (such as wetting/soiling pants, bed-wetting)?

- ☐ Yes
- ☐ No
- ☐ Don't know

Did the child ever have a head injury?

- ☐ Yes
- ☐ No
- ☐ Don't know

Did the child ever have a broken bone?

- ☐ Yes
- ☐ No
- ☐ Don't know

Before the age of 3 years, did the child have constant ear infections?

- ☐ Yes
- ☐ No
- ☐ Don't know

Did the child ever take a poison or too much medicine?

- ☐ Yes
- ☐ No
- ☐ Don't know

Has the child wished to die or hurt himself/herself?

- ☐ Yes, recently and in the past
- ☐ Yes, recently
- ☐ Yes, in the past
- ☐ No
- ☐ Don't know

Has the child tried to hurt himself/herself?

- ☐ Yes, recently and in the past
- ☐ Yes, recently
- ☐ Yes, in the past
- ☐ No
- ☐ Don't know

Does the child hurt pets or small children?

- ☐ Yes
- ☐ No
- ☐ Don't know

Have any of the child's caretakers been accused of child neglect or abuse?

- ☐ Yes
- ☐ No
- ☐ Don't know

The primary caretakers had problems in their relationship:

- ☐ During the pregnancy
- ☐ Curing the child's infancy
- ☐ During the child's early childhood (2 to 7)
- ☐ After the child was 7 years old
- ☐ No problems
- ☐ Don't know

The primary caretakers had problems such as:

- ☐ Constant arguing
- ☐ Constant shouting
- ☐ Breaking things
- ☐ Physically hitting each other
- ☐ Threatening to leave
- ☐ None of the above
- ☐ Don't know

The child's caretakers are currently:

- ☐ Married
- ☐ In a relationship together
- ☐ Separated
- ☐ Divorced
- ☐ In a relationship with someone who is not the child's other caretaker
- ☐ Don't know

Were the child's caretakers married?

- ☐ Yes
- ☐ No

If **YES**, also answer the following three questions:

Has the child experienced the divorce of their primary caretakers?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

Has the child's mother been remarried?

- ☐ Yes
- ☐ No
- ☐ Don't know

Has the child's father been remarried?

- ☐ Yes
- ☐ No
- ☐ Don't know

Did the child attend day care before the age of 3 years?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

Did the child go to nursery school?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

Did the child go to kindergarten?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

Which of the following describes the child in the early grades?

- ☐ Does not apply
- ☐ Happy
- ☐ Well-adjusted
- ☐ Sad
- ☐ Hard to leave
- ☐ Withdrawn
- ☐ Fearful
- ☐ Cried when left
- ☐ Hurt other children
- ☐ Had problems with teachers
- ☐ Had problems with making friends
- ☐ Had problems doing the work
- ☐ Don't know

Does the child have behavior problems in school now?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

Does the child have learning problems in school now?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

Has the child had problems learning to read?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

Has the child ever had special testing for school problems?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

Has the child ever been placed in any special or exceptional class?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

Is the child in special or exceptional education class now?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

Has the child ever been in counseling?

- ☐ Yes
- ☐ No
- ☐ Don't know

Does the child have trouble making or keeping friends?

- ☐ Yes
- ☐ No
- ☐ Don't know

Did the child ever set a fire?

- ☐ Yes, recently and in the past
- ☐ Yes, recently
- ☐ Yes, in the past
- ☐ No
- ☐ Don't know

Does the child hear or see things that are not there?

- ☐ Yes
- ☐ No
- ☐ Don’t know

Does the child often seem to be in a world of his/her own?

- ☐ Yes
- ☐ No
- ☐ Don’t know

Does the child have a hearing problem?

- ☐ Yes
- ☐ No
- ☐ Don’t know

Does the child have a vision problem?

- ☐ Yes
- ☐ No
- ☐ Maybe
- ☐ Don’t Know

Family have had the following:

- ☐ Epilepsy
- ☐ Emotional problems
- ☐ Delinquency
- ☐ Reading problems
- ☐ Alcoholism
- ☐ Suicide
- ☐ Learning problems
- ☐ None of the above
- ☐ Drug abuse
- ☐ Don’t know

MEDICAL HISTORY

Is your child experiencing physical pain at this time?

- ☐ Yes
- ☐ No

If “Yes”, continue below, if “No”, skip to the underlined question ON NEXT PAGE

What part of your child’s body typically hurts the most?

- ☐ Head
- ☐ Neck
- ☐ Back
- ☐ Stomach
- ☐ Upper limbs
- ☐ Lower limbs
- ☐ Several body areas
- ☐ Entire body
- ☐ Note of the above

How long has your child been having these pains?

- ☐ Within the past six months
- ☐ Six months to one year
- ☐ Two to four years
- ☐ Over four years

How severe has the pain been recently?

- ☐ Mild
- ☐ Discomforting
- ☐ Distressing
- ☐ Horrible
- ☐ Beyond description

How often does this pain occur?

- ☐ Monthly
- ☐ Weekly
- ☐ Daily
- ☐ All the time

How often does your child take prescribed medications for this pain?

- ☐ Never
- ☐ Seldom
- ☐ Occasionally
- ☐ Often
- ☐ Frequently
- ☐ All the time

Does your child use any of the following to reduce the pain?

- ☐ Heat/cold treatment
- ☐ Electrical stimulation or TENS unit
- ☐ Physical therapy or exercises
- ☐ Lie down
- ☐ None of the above

Does your child have a history of seizures or convulsions?

- ☐ Yes
- ☐ No

If “Yes” continue below, if “No” skip to **Do you now or feel that your child has experimented with any of the following substances?**

What type of seizures have you experienced?

- ☐ Absence (Petit Mal)
- ☐ Myoclonic
- ☐ Clonic
- ☐ Tonic-Clonic (Grand Mal)
- ☐ Atonic
- ☐ Simple Partial
- ☐ Complex Partial (Temporal Lobe)
- ☐ West Syndrome
- ☐ Lennox-Gastaut Syndrome
- ☐ Status Epilepticus
- ☐ Jacksonian
- ☐ Unclassified Epileptic
- ☐ Other

Approximately what year did your child’s seizures begin? ________________________

When was your child’s last seizure?

- ☐ Earlier today
- ☐ Yesterday
- ☐ Earlier this week
- ☐ Earlier this month
- ☐ During the past year
- ☐ One to five years ago
- ☐ Six to ten years ago
- ☐ Eleven to fifteen years ago
- ☐ Sixteen to twenty years ago
- ☐ Over twenty years

Does your child take medication to control seizures?

- ☐ Yes
- ☐ No

Do you now or feel that your child has experimented with any of the following substances?

- ☐ Tobacco
- ☐ Marijuana
- ☐ Cocaine
- ☐ “Designer” drugs
- ☐ Hallucinogens
- ☐ Alcohol
- ☐ Amphetamines (meth)
- ☐ Steroids
- ☐ Inhalants (huffing)
- ☐ Prescription medication (non-medicinal use)
- ☐ Spice
- ☐ Heroin
- ☐ None of the listed items

Do you know or feel that your child has a significant substance abuse problem?

- ☐ Yes
- ☐ No
- ☐ Don't know

Has your child received inpatient rehab treatment for substance abuse?

- ☐ Yes
- ☐ No

GENERAL INFORMATION

MEDICAL HISTORY: List major illnesses and injuries. Provide approximate year of each illness or injury, and treatment received. Provide serious childhood illnesses, injuries or surgeries.

☐Check here if this does not apply because your child has never had major illness or injury.

YEAR	HEALTH PROBLEM	TREATMENT RECEIVED

PSYCHIATRIC HISTORY: List psychiatric illnesses and mental health treatment.

☐Check here if this does not apply because your child has never had mental health treatment.

YEAR	TYPE OF PROBLEM	TREATMENT RECEIVED

CURRENT PRESCRIPTION MEDICATIONS: List all prescription medications your child is currently taking.

☐Check here if this does not apply because your child is not taking prescription medications.

MEDICATION	PRESCRIBED BY	REASON FOR MEDICATION

DAILY ACTIVITY – CHILD

Social Activities:

- ☐ Talks with family members nearly every day
- ☐ Talks with friends and neighbors fairly often
- ☐ Uses a phone to call family and friends
- ☐ Goes to eat with family and friends
- ☐ Occasionally goes out to eat with family and friends
- ☐ Often corresponds using letters, emails or texting
- ☐ Occasionally corresponds using letters, email or texting
- ☐ Attends church
- ☐ None of the above

Engages in recreational activities, including:

- ☐ Shopping or window shopping
- ☐ Walking
- ☐ Running
- ☐ Swimming
- ☐ Visiting at friend's house
- ☐ Going to movies
- ☐ Having friends over
- ☐ Watching TV
- ☐ Listening to music
- ☐ Travel – to where:____________________
- ☐ Playing with children
- ☐ Playing cards or games
- ☐ Other (specify):______________________
- ☐ None of the listed activities

Does the following chores around the house: (Check all that apply. If you need help doing a chore, also place an "**" to the left of the check box.)

- ☐ Cooking
- ☐ Washing dishes
- ☐ Cleaning house
- ☐ Vacuuming
- ☐ Laundry
- ☐ Watering the lawn
- ☐ Mowing the lawn
- ☐ Gardening
- ☐ Taking care of pets
- ☐ Taking care of children
- ☐ Taking care of adults
- ☐ None of the above

Care of self:

- ☐ Can bathe self in the tub
- ☐ Can bathe self in the shower
- ☐ Can dress self
- ☐ Can take care of hair
- ☐ Can take care of clothing
- ☐ None of the above

Thinking and Reasoning:

- ☐ Can concentrate on a task until finished
- ☐ Understands and remembers what was read
- ☐ Understands and remembers programs seen on TV
- ☐ None of the above

Interests and activities still include:

- ☐ None of the activities listed
- ☐ Reading
- ☐ Conversation
- ☐ Keeping up with the news
- ☐ Making money by: ____
- ☐ Hobbies, including ____
- ☐ Crafts, including ____
- ☐ Family activities
- ☐ Enjoying friends
- ☐ Physical exercise

My child wakes up at: ____

On his/her own?
- ☐ Yes
- ☐ No

If not how does your child wake up?
____

Morning activities (6:00 a.m. to noon):________________________________
____
____

At lunchtime, my child:____
____
____

Afternoon activities (1:00 p.m. to 6:00 p.m.): ___________________________
____
____

Evening activities (6:00 p.m. to bedtime): ______________________________
____
____

My child goes to bed at: ________________________________

Describe your child's quality of sleep: __________________________________
____
____
____

Does your take medication to help sleep?:
- ☐ Yes
- ☐ No

If yes what kind of medication?:___________________

Does your child require assistance to fall asleep?:

- ☐ Yes
- ☐ No

If yes what type?: ____