

# Chattahoochee Child Psychology, LLC

## Social History Information

Client's Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender:  F  M  Non-Binary  Transgender Female  Transgender Male  Other

Client's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Race/Ethnicity: \_\_\_\_\_

Grade in school: \_\_\_\_\_ School Attending: \_\_\_\_\_

Respondent's Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

**If you need any more space for any of the following questions please use the back of the sheet.**

Primary reason(s) for seeking services:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Anger management                              | <input type="checkbox"/> Eating disorder  | <input type="checkbox"/> Sleeping problems   |
| <input type="checkbox"/> Anxiety                                       | <input type="checkbox"/> Fear/phobias     | <input type="checkbox"/> Addictive behaviors |
| <input type="checkbox"/> Coping  | <input type="checkbox"/> Mental confusion | <input type="checkbox"/> Alcohol/drugs       |
| <input type="checkbox"/> Depression                                    | <input type="checkbox"/> Sexual concerns  | <input type="checkbox"/> Hyperactivity       |
| <input type="checkbox"/> Other mental health concerns (specify): _____ |   |  |

### Family History

#### Parents/Guardians:

With whom does the child live at this time? \_\_\_\_\_

Marital Status of Biological Parents:  Married  Divorced  Separated  Never Married  
 Other (specify): \_\_\_\_\_

If biological parents are not currently married, who has legal custody? \_\_\_\_\_

Has there been a court decision regarding custody?  Yes  No

If yes, do you have copies of the custody papers?  Yes  No

(Note: If a court has awarded guardianship, verification of legal guardianship must be provided to your provider/the office prior to initiation of treatment.)

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling?  Yes  No

If Yes, describe: \_\_\_\_\_

#### Client's 1<sup>st</sup> Parent/Guardian:

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Gender:  F  M  Non-Binary  Transgender Female  Transgender Male  Other

Occupation: \_\_\_\_\_  Full Time  Part Time

Where employed: \_\_\_\_\_ Work phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Parent/Guardian's Highest Level of Education: \_\_\_\_\_

Is the child currently living with parent/guardian?  Yes  No

Parent/Guardian is:  Natural parent  Step-parent  Adoptive parent  Foster parent

Other (specify): \_\_\_\_\_

Is there anything notable, unusual or stressful about the child's relationship with the parent/guardian?

Yes  No If Yes, please explain: \_\_\_\_\_

How is the child usually disciplined by the parent/guardian? \_\_\_\_\_

What are the child's typical misbehaviors? For what reasons is the child disciplined by the parent/guardian?

**Client's 2<sup>nd</sup> Parent/Guardian:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Gender:  F  M  Non-Binary  Transgender Female  Transgender Male  Other

Occupation: \_\_\_\_\_  Full Time  Part Time

Where employed: \_\_\_\_\_ Work phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Parent/Guardian's Highest Level of Education: \_\_\_\_\_

Is the child currently living with parent/guardian?  Yes  No

Parent/Guardian is:  Natural parent  Step-parent  Adoptive parent  Foster parent

Other (specify): \_\_\_\_\_

Is there anything notable, unusual or stressful about the child's relationship with the parent/guardian?

Yes  No If Yes, please explain: \_\_\_\_\_

How is the child usually disciplined by the parent/guardian? \_\_\_\_\_

What are the child's typical misbehaviors? For what reasons is the child disciplined by the parent/guardian?

**Client's Siblings and Others Who Live in the Household:**

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	<input type="checkbox"/> home <input type="checkbox"/> away	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good

Comments: \_\_\_\_\_

Others living in the household	Age	Gender	Relationship to client (e.g., cousin, foster child)	Quality of relationship with client
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	_____	<input type="checkbox"/> poor <input type="checkbox"/> average <input type="checkbox"/> good

Comments: \_\_\_\_\_

Who is primarily responsible for your child in the following areas?

School: Mother Father Shared Other (specify): \_\_\_\_\_  
Health: Mother Father Shared Other (specify): \_\_\_\_\_  
Problem behaviors: Mother Father Shared Other (specify): \_\_\_\_\_

**Client's Childhood/Adolescent History**

**Pregnancy/Birth:**

Has the child's mother had any occurrences of miscarriages or stillborns? Yes No

If Yes, describe: \_\_\_\_\_

Was the pregnancy with child planned? Yes No

Mother's age at child's birth: \_\_\_\_\_ Father's age at child's birth: \_\_\_\_\_

Child is number \_\_\_\_\_ of \_\_\_\_\_ total children.

Length of pregnancy: \_\_\_\_\_ weeks, \_\_\_\_\_ days

Length of labor: \_\_\_\_\_ hours Induced: Yes No Caesarean? Yes No

Birth weight: \_\_\_\_\_ lbs, \_\_\_\_\_ oz Baby's birth length: \_\_\_\_\_ inches

Length of hospitalization after birth: Mother: \_\_\_\_\_ days Baby: \_\_\_\_\_ days

**Infancy/Toddlerhood** Check all which apply:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Breast fed     | <input type="checkbox"/> Colic            | <input type="checkbox"/> Overactive              |
| <input type="checkbox"/> Bottle fed     | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Resisted solid food     |
| <input type="checkbox"/> Milk allergies | <input type="checkbox"/> Febrile Seizures | <input type="checkbox"/> Sleep problems          |
| <input type="checkbox"/> Vomiting       | <input type="checkbox"/> Not cuddly       | <input type="checkbox"/> Irritable when awakened |
| <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Cried often      | <input type="checkbox"/> Lethargic               |
| <input type="checkbox"/> Rashes         | <input type="checkbox"/> Rarely cried     |  |

**Client's Educational History**

Is child in Special Education? No Yes, describe: \_\_\_\_\_

Is child in Gifted Education? No Yes, describe: \_\_\_\_\_

Has child ever been held back/repeat grade in school? No Yes, what grade(s), describe: \_\_\_\_\_

Which subjects does the child enjoy in school? \_\_\_\_\_

Which subjects does the child dislike in school? \_\_\_\_\_

What grades does the child usually receive in school? \_\_\_\_\_

Have there been any recent changes in the child's grades? No Yes, describe: \_\_\_\_\_

Has the child ever received psychological testing? No Yes, describe (reason, findings): \_\_\_\_\_

Check the descriptions which specifically relate to your child:

**Feelings about School Work:**

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Anxious      | <input type="checkbox"/> Eager         | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Passive      | <input type="checkbox"/> No expression | _____  |
| <input type="checkbox"/> Enthusiastic | <input type="checkbox"/> Bored         |  |
| <input type="checkbox"/> Fearful      | <input type="checkbox"/> Rebellious    |  |

**Approach to School Work:**

- Organized
- Industrious
- Responsible
- Interested
- Self-directed
- No initiative
- Refuses
- Does only what is expected
- Sloppy
- Disorganized
- Cooperative
- Doesn't complete assignments
- Other (describe): \_\_\_\_\_

**Performance in School (Parent's Opinion):**

- Satisfactory
  - Underachiever
  - Overachiever
  - Other (describe): \_\_\_\_\_
- 

**Client's Employment History**

Does the client have a job or participate in a vocational program?  No (skip this section)  Yes  
 What is the client's attitude toward work?  Poor  Average  Good  Excellent  
 Current employer: \_\_\_\_\_ Position: \_\_\_\_\_ Hours per week: \_\_\_\_\_  
 How have the client's school grades been affected since working?  Lower  Same  Higher  
 How many previous jobs or placements has the child had? \_\_\_\_\_  
 Usual length of employment: \_\_\_\_\_ Usual reason for leaving: \_\_\_\_\_

**Child's Social History**

**Child's Peer Relationships:**

- Spontaneous
- Follower
- Leader
- Difficulty making friends
- Makes friends easily
- Long-time friends
- Shares easily
- Other (describe): \_\_\_\_\_

**Leisure/Recreational:**

Describe activities, special areas of interest, or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.). Note any change in level of interest/involvement since onset of problematic symptoms/behaviors.

Activity/Interest	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Counseling/Prior Treatment History**

Information about child/adolescent (past and present):

	No	Yes	When	Where	Reaction or overall experience		
Counseling/Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Bad	<input type="checkbox"/> Neutral
Drug/alcohol treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Bad	<input type="checkbox"/> Neutral
Psychiatrist/Medication	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Bad	<input type="checkbox"/> Neutral
Psychiatric Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Bad	<input type="checkbox"/> Neutral
Residential Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Bad	<input type="checkbox"/> Neutral

**Current Behavioral/Emotional Functioning**

Please check any of the following that are typical for your child:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Affectionate           | <input type="checkbox"/> Gambling             | <input type="checkbox"/> Selfish               |
| <input type="checkbox"/> Aggressive             | <input type="checkbox"/> Generous             | <input type="checkbox"/> Separation anxiety    |
| <input type="checkbox"/> Alcohol problems       | <input type="checkbox"/> Hallucinations       | <input type="checkbox"/> Sets fires            |
| <input type="checkbox"/> Angry                  | <input type="checkbox"/> Head banging         | <input type="checkbox"/> Sexual addiction      |
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Heart problems       | <input type="checkbox"/> Sexual acting out     |
| <input type="checkbox"/> Attachment to dolls    | <input type="checkbox"/> Hopelessness         | <input type="checkbox"/> Shares                |
| <input type="checkbox"/> Avoids adults          | <input type="checkbox"/> Hurts animals        | <input type="checkbox"/> Sick often            |
| <input type="checkbox"/> Bedwetting             | <input type="checkbox"/> Imaginary friends    | <input type="checkbox"/> Short attention span  |
| <input type="checkbox"/> Blinking, jerking      | <input type="checkbox"/> Impulsive            | <input type="checkbox"/> Shy, timid            |
| <input type="checkbox"/> Bizarre behavior       | <input type="checkbox"/> Irritable            | <input type="checkbox"/> Sleeping problems     |
| <input type="checkbox"/> Bullies, threatens     | <input type="checkbox"/> Lazy                 | <input type="checkbox"/> Slow moving           |
| <input type="checkbox"/> Careless, reckless     | <input type="checkbox"/> Learning problems    | <input type="checkbox"/> Soiling               |
| <input type="checkbox"/> Chest pains            | <input type="checkbox"/> Lies frequently      | <input type="checkbox"/> Speech problems       |
| <input type="checkbox"/> Clumsy                 | <input type="checkbox"/> Listens to reason    | <input type="checkbox"/> Steals                |
| <input type="checkbox"/> Confident              | <input type="checkbox"/> Loner                | <input type="checkbox"/> Stomach aches         |
| <input type="checkbox"/> Cooperative            | <input type="checkbox"/> Low self-esteem      | <input type="checkbox"/> Suicidal threats      |
| <input type="checkbox"/> Cyber addiction        | <input type="checkbox"/> Messy                | <input type="checkbox"/> Suicidal gestures     |
| <input type="checkbox"/> Defiant                | <input type="checkbox"/> Moody                | <input type="checkbox"/> Suicidal attempts     |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Nightmares           | <input type="checkbox"/> Talks back            |
| <input type="checkbox"/> Destructive            | <input type="checkbox"/> Obedient             | <input type="checkbox"/> Teeth grinding        |
| <input type="checkbox"/> Difficulty speaking    | <input type="checkbox"/> Often sick           | <input type="checkbox"/> Thoughts of death     |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Oppositional         | <input type="checkbox"/> Thumb sucking         |
| <input type="checkbox"/> Drugs dependence       | <input type="checkbox"/> Over active          | <input type="checkbox"/> Tics and twitching    |
| <input type="checkbox"/> Eating disorder        | <input type="checkbox"/> Overweight           | <input type="checkbox"/> Unsafe behaviors      |
| <input type="checkbox"/> Enthusiastic           | <input type="checkbox"/> Panic attacks        | <input type="checkbox"/> Unusual thinking      |
| <input type="checkbox"/> Excessive masturbation | <input type="checkbox"/> Phobias              | <input type="checkbox"/> Weight loss           |
| <input type="checkbox"/> Expects failure        | <input type="checkbox"/> Poor appetite        | <input type="checkbox"/> Withdrawn             |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Worries excessively   |
| <input type="checkbox"/> Fearful                | <input type="checkbox"/> Quarrels             | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> Frequent injuries      | <input type="checkbox"/> Racing thoughts      | _____  |
| <input type="checkbox"/> Frustrated easily      | <input type="checkbox"/> Sad                  | _____  |

Please describe any of the above (or other) concerns: \_\_\_\_\_

How are problem behaviors generally handled? \_\_\_\_\_  
\_\_\_\_\_

What are the family's favorite activities? \_\_\_\_\_  
\_\_\_\_\_

What does the client do with his/her free time? \_\_\_\_\_  
\_\_\_\_\_

Has the child/adolescent experienced death? (friends, family pets, other)  Yes  No  
If yes, at what age? \_\_\_\_\_ Describe the child's/adolescent's reaction: \_\_\_\_\_  
\_\_\_\_\_

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)  
 Yes  No If Yes, describe: \_\_\_\_\_  
\_\_\_\_\_

Please describe any religious or cultural factors that may impact your child's treatment: \_\_\_\_\_  
\_\_\_\_\_

Please add any additional information that you believe would be helpful in understanding your  
child/adolescent: \_\_\_\_\_  
\_\_\_\_\_

Please add any additional information that would be helpful in understanding current concerns or problems:  
\_\_\_\_\_  
\_\_\_\_\_

What are your goals for your child's therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For Staff Use**

Date Reviewed: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Provider's signature/credentials: \_\_\_\_\_