Glens Falls City School District

SOCIAL HISTORY
CONFIDENTIAL

Date Completed:_____

Student:_____DOB:_____Sex:_____

Home Address:_____Age:_____

School:_____Grade:_____

Home Phone:_____

A. CURRENT PARENT/GUARDIAN DATA

Father:_____ Mother:_____

Address:_____ Address:_____

Home Phone:_____ Home Phone:_____

Occupation:_____ Occupation:_____

Place of Employment:_____ Place of Employment:_____

Work Phone:_____Work Hours:_____ Work Phone:_____Work Hours:_____

Emergency Contact: Name:_____ Phone:_____

B. SIGNIFICANT FAMILY MEMBERS

Name	DOB	Relationship	Highest Grade Completed	In Home Out of Home (Please Check One)	

C. HEALTH/DEVELOPMENT OF CHILD

1. A. Prenatal care/pregnancy (OB/GYN):

B. Medications during pregnancy:

C. Delivery specifics:

D. Birth weight & length:

E. Established feeding and sleeping patterns during the first year (problems):

2. Developmental milestones:

age: _____Sat Comments:_____
_____Walked _____
_____Talked _____
_____Toilet Trained _____

Fine motor concerns:

Large motor concerns:

3. Does your child receive regular health care?

Type of insurance:

Doctor?

Has your child ever been evaluated by a specialist?

When was your child's last well-child visit?

When was your child's last doctor visit for illness?

4. Please describe any that apply, indicate date(s), and attending Physician's name:

Frequent headaches:

Serious Fevers:

Seizures:

Diseases:

Allergies:

Serious Injuries:

Head Injuries:

Hospitalizations:

Hearing:

Vision:

Other:

5. Prescribed medications (name of medication, dates begun and ended):

6. Please list any significant health problems your child has experienced:

D. CHILD CHARACTERISTICS

1. How would you describe your child's "personality"?

Please check the terms that most closely describe your child:

_____Self Confident	_____Independent	_____Fearful	_____Disobedient	_____Happy
_____Easy Going	_____Anxious	_____Worried	_____Depressed	_____Active
_____Responsible	_____Changeable	_____Passive	_____Clinging	_____Unkind
_____Withdrawn	_____Outgoing	_____Cruel	_____Considerate	_____Shy
_____Thoughtless	_____Unfriendly	_____Friendly	_____Aggressive	
_____Cooperative	_____Forgetful	_____Hostile	_____Defiant	

_____Other_____

2. What is your child's relationship with significant family members? (parents, siblings, grandparents)

3. Is there a second language spoken in your family?

4. With whom does your son/daughter usually associate?

_____Older children **_____Same sex**
_____Younger children **_____Opposite sex**
_____Same age **_____Mixed group**

5. Does your child form friendships easily?

6. What are your child's favorite activities?

7. What kind of disciplinary techniques do you use with your child?

Are they effective?

8. How does your child respond to authority? (home/school)

9. Does your child exhibit any behaviors/traits, which are of concern to you? Have you noticed any changes in his/her personality? (e.g.temper tantrums, phobias, bed-wetting, sleep or eating problems)

10. Has anyone in your family had difficulty because of drug or alcohol use?

11. Has your child had any work experiences? Paid or Unpaid?

E. SCHOOL HISTORY

1. Preschool/Nursery school:

Grade School	Location	Dates Attended

2. Please indicate your child's favorite:

Teacher's	Grade(s)	Subject(s)

3. Has your child ever been retained? Yes____No____ What grade(s):

4. What are your child's academic strengths?

5. What are your child's academic weaknesses?

6. Does your child have any special needs in the classroom, cafeteria, library, gym, playground, or bus?

F. SIGNIFICANT FAMILY EVENTS

1. Describe major changes within the family (e.g. separation, divorce, death of significant others, incarceration, suicide, employment, adoption, recent births, foster care, physical or sexual abuse).

How has your child dealt with these changes?

2. Describe major family health issues and their effects on your child (e.g. lengthy injuries, serious illness, mental illness, substance abuse, etc.)

How has your child dealt with these changes?

3. Has anyone in your family had difficulty in school (e.g. ADD/ADHD, learning/behavior problems).

G. HUMAN SERVICE INVOLVEMENT

1. Private or professional counseling: Date(s): _____
Location(s): _____
Contact Person: _____
Please describe: _____

2. Public Assistance: SSI or Medicaid: Date(s): _____
Location(s): _____
Contact Person: _____
Please describe: _____

3. Community Service/Interventions
Big Brothers/Big Sisters _____
PINS/Probation _____
ICM _____
Support Services _____
Case Magnement _____
Preventive Services _____
CPS _____
Family Advocate_____
School Sponsered Activities _____

H. PROGRAM DEVELOPMENT

1. Is there any information that would assist us in developing an appropriate program for your child?

2. What are your goals for your child?

Person providing data: _____ Relationship to child: _____

Person collection data: _____ Title: _____