

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:

<input type="checkbox"/> Self Confident	<input type="checkbox"/> Independent	<input type="checkbox"/> Fearful	<input type="checkbox"/> Disobedient	<input type="checkbox"/> Happy
<input type="checkbox"/> Easy Going	<input type="checkbox"/> Anxious	<input type="checkbox"/> Worried	<input type="checkbox"/> Depressed	<input type="checkbox"/> Active
<input type="checkbox"/> Responsible	<input type="checkbox"/> Changeable	<input type="checkbox"/> Passive	<input type="checkbox"/> Clinging	<input type="checkbox"/> Unkind
<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Outgoing	<input type="checkbox"/> Cruel	<input type="checkbox"/> Considerate	<input type="checkbox"/> Shy
<input type="checkbox"/> Thoughtless	<input type="checkbox"/> Unfriendly	<input type="checkbox"/> Friendly	<input type="checkbox"/> Aggressive	
<input type="checkbox"/> Cooperative	<input type="checkbox"/> Forgetful	<input type="checkbox"/> Hostile	<input type="checkbox"/> Defiant	
<input type="checkbox"/> 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 Management \_\_\_\_\_

Preventive Services \_\_\_\_\_

CPS \_\_\_\_\_

Family Advocate \_\_\_\_\_

School Sponsored 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: \_\_\_\_\_