Community Behavioral Services

SOCIAL HISTORY (child/adolescent)

Name: _____ Age:_____ Sex: _____

Reporter: _____ Relationship:_____

DEVELOPMENTAL/ FAMILY HISTORY:

Where was this child born? _____

How many brothers? _____ How many sisters? _____

Where does he/she fall in birth order? _____

Were this child's parents together while they were growing up? ……...Yes ☐ No ☐

How old was this child when their parents separated? _____

Who raised this child?_____

Were there stepparents or significant others living in the home?……..……Yes ☐ No ☐

What was the relationship like between this child and family members? _____
_____

Was anything unusual about this child's early developmental years? (walking, talking, etc.)
Yes ☐ No ☐ If so, explain _____
_____

Was this child ever the victim of physical abuse? Yes ☐ No ☐ Sexual abuse? Yes ☐ No ☐

Was this child ever the victim of emotional abuse? ……..……. Yes ☐ No ☐

Were there any other traumatic experiences in this child's early life?……. Yes ☐ No ☐
If so, explain _____

How was this child disciplined?_____
_____

Was it effective? …… Yes ☐ No ☐

Notes:

Did this child ever witness violence in their home? ……...……Yes ☐ No ☐

ACADEMIC FUNCTIONING:

What grade is this child in?_____

How would you describe this child's grades? Below Average ☐ Average ☐ Above Average ☐

Is this child attending school? ……..…Yes ☐ No ☐
If not, why?_____

Was this child ever held back any years, or placed in any special classes or programs?
Yes ☐ No ☐ Is so, explain _____
_____

Did this child have behavioral problems in the school setting? (i.e. fights, suspensions, referrals, etc?) Yes ☐ No ☐ If so, explain_____
_____
_____

How many fights did this child get in during their school years? _____

Was it easy for this child to make friends during their school years? ..…..…...Yes ☐ No ☐

Was/Is this child involved in any clubs, sports, or other out of school structured activities?
Yes ☐ No ☐ Explain: _____
_____

Did this child ever run away from home? ……..……...Yes ☐ No ☐

How was this child's behavior at home during their school years?_____
_____

Were there any unusual or traumatic events which occurred during this period of their life?
Yes ☐ No ☐ Explain: _____
_____

Notes:

CURRENT CIRCUMSTANCES:

With whom does this child currently live? _____

List the names, age and relationship of all individuals living in the household_____
_____
_____

Does this child have any strong religious affiliations? …..…….. Yes ☐ No ☐

Is this child involved in any clubs, organizations, gangs, etc? ……... Yes ☐ No ☐

Does this child spend most of their time …..……...with other people ☐ or alone? ☐

Is it difficult for this child to make friends? …..……..……... Yes ☐ No ☐

Does this child maintain friendships for long periods of time? …..……..Yes ☐ No ☐

Have any of this child's friendships ended in anger or violence? ……Yes ☐ No ☐

What types of activities does this child typically engage in with friends? _____
_____

What is the age range of most of this child's friends? ….. Same age ☐ Older ☐ Younger ☐

Do you believe this child has difficulties with their temper (anger)? …….. Yes ☐ No ☐

Would others agree with your opinion on this issue? ……..…….Yes ☐ No ☐

What types of things makes this child angry? _____
_____

When this child gets angry how do they handle it? _____
_____

Does this child own or have access to any weapons? …..…….Yes ☐ No ☐

Where are they? _____
_____

Notes:

DRUGS AND ALCOHOL:

How often and how much does this child drink? _____

What is the most they have drunk on any one occasion? _____

When was the last time they drank alcohol? _____

List all drugs that they use and indicate the frequency and quantity of all use: _____
_____
_____

When was the last time this child used any illegal drugs? _____

Have you ever noticed that this child needed increased amounts of drugs or alcohol to achieve the same high? ……...Yes ☐ No ☐

Have you noticed drugs and alcohol having less of an effect on this child if they continue to use the same amount? ……..Yes ☐ No ☐

If this child refrains from drugs and alcohol or are unable to obtain them, do they experience any withdrawal symptoms? ……Yes ☐ No ☐

Has your child ever used drugs and alcohol in larger amounts or over a longer period of time than was intended? …….Yes ☐ No ☐

Does this child experience cravings or persistent desire for drugs or alcohol? …Yes ☐ No ☐

Has this child's efforts to cut down or control their drug or alcohol use been unsuccessful? ……..Yes ☐ No ☐

Does this child spend a great deal of time in activities necessary to obtain drugs and alcohol? ……..…….....Yes ☐ No ☐

Has this child ever given up activities or involvements because of their use of drugs and alcohol? …….Yes ☐ No ☐

Has this child continued using drugs and alcohol despite knowing that it is causing problems for them? …..……...Yes ☐ No ☐

How old was this child the first time they used alcohol? _____

Notes:

How old was this child the first time they used Illegal drugs? _____

List all street drugs that this child has used in the past: _____
_____

Describe this child's consumption of drugs and alcohol at the point in this child's life when they were using the heaviest: _____
_____

How old was this child during this period in their life? _____

Has this child ever received any drug or alcohol related arrests? ……Yes ☐ No ☐

Has this child ever experienced any substance-induced blackouts? …….Yes ☐ No ☐

Has your child ever been treated in a drug or alcohol facility? ……..Yes ☐ No ☐

MEDICAL HISTORY:

Briefly describe all current medical conditions: _____
_____
_____

List all medications and dosages (including over-the-counter) that this child is currently taking:
_____
_____
_____

List any head injuries or surgeries:_____
_____
_____

PSYCHIATRIC HISTORY:

How old was this child the first time they received any counseling or psychiatric care? _____

Notes:

List all treatment (inpatient and outpatient) in chronological order along with the reason for the treatment and whether the treatment was helpful. _____
_____
_____
_____

What conditions were this child diagnosed as suffering from: _____
_____
_____

Has this child ever taken medications for emotional or psychiatric conditions? Yes ☐ No ☐

List any medications that this child has taken in the past, and their current medication and dosage.
Past: _____

Present: _____

Is there a history of mental illness in this child's family (biological relatives)? Yes ☐ No ☐

LEGAL HISTORY:

List all criminal charges, the disposition of the case and any time served (include arrests as a juvenile) _____
_____
_____
_____

Does this child currently have any charges pending against them? …….Yes ☐ No ☐

Describe all civil lawsuits that this child has been involved in? _____
_____

OCCUPATIONAL FUNCTIONING:

Has this child ever had a job? ……...Yes ☐ No ☐

What is the longest period of time spent on one job? _____

Why did this child leave that position? _____

Notes:

Has this child ever been fired from a job? ……....Yes ☐ No ☐

Why? _____
_____
_____

Has this child had behavioral difficulties in the job setting such as getting along with bosses and co-workers? …..……..Yes ☐ No ☐

Where is this child currently employed? _____

How long have they been in this position? _____

ANGER MANAGEMENT:

How often does this child get angry (daily, weekly, etc)? _____

How long does this child stay angry toward someone? _____

When this child is angry is their behavior a problem? …….Yes ☐ No ☐

Does this child ever throw things or hit things when they are angry? ..…….Yes ☐ No ☐

Does this child yell and scream when they are angry? ……..……... Yes ☐ No ☐

What does this child do to calm their self down when they are angry? _____
_____

Has this child ever felt so angry that they thought intentionally of hurting or killing someone else? ……Yes ☐ No ☐

If yes, please describe: _____
_____
_____

Notes:

Community Behavioral Services

Problem Checklist

Name:_____Date:_____Age:_____

Place a check mark by any of the following difficulties that you have experienced during ***the past 6 month***

- ❑ Depressed mood.
- ❑ Periods of excessive sadness.
- ❑ Mood swings.
- ❑ Periods of feeling too good, or too energetic.
- ❑ Loss of energy.
- ❑ Too much energy.
- ❑ Times you are feeling so good, high, or excited, that other people thought that you were not your normal self or that you got into trouble.
- ❑ Periods when you were so irritable that you found yourself shouting at people, starting fights, or arguments.
- ❑ Increased need for sleep.
- ❑ Decreased need for sleep.
- ❑ Difficulties in attention or concentration/ being easily distracted.
- ❑ Racing thoughts.
- ❑ Increased agitation or irritability.
- ❑ Feeling anxious or nervous a great deal of the time.
- ❑ Feeling scared a lot of the time.
- ❑ Phobias or fears which have interfered in your ability to live a normal life.
- ❑ Periods of panic.
- ❑ Pain for which there is no physical cause.
- ❑ Physical difficulties for which your physician reports there is no cause.
- ❑ Excessive worry or stress.
- ❑ Sleep disturbance.
- ❑ Nightmares.
- ❑ Loss of job.
- ❑ Difficulties in your relationships with people.
- ❑ Periods of isolation.
- ❑ Academic or learning difficulties.
- ❑ Behavioral problems at home or at school.
- ❑ Hyperactivity/ impulsively.
- ❑ Stealing, lying, hurting others.
- ❑ Actions or behaviors that you feel compelled to do, over and over again, that you have been unable to resist doing.
- ❑ Any behavior you have been unable to control or stop.
- ❑ Uncontrollable urges to commit inappropriate acts such as stealing, setting fires, fighting, etc.
- ❑ Low self-esteem.
- ❑ Failure to comply with recommended medical or psychological treatment.
- ❑ Abuse or neglect of a child.
- ❑ Domestic violence.
- ❑ Abuse or neglect of an elderly person.
- ❑ Marital difficulties.
- ❑ A serious loss or trauma.
- ❑ Problems with alcohol use.
- ❑ Problems with drug use.
- ❑ Appetite disturbances.

- ❑ Excessive weight loss.
- ❑ Inability to maintain your normal weight.
- ❑ The use of purging or medications to control your weight.
- ❑ Decreased sexual desire.
- ❑ Difficulty in sexual performance.
- ❑ Unusual or disturbing sexual interests or fantasies.
- ❑ Memory loss.
- ❑ Blackouts.
- ❑ Periods of time which are unaccounted for, or you cannot recall what happened.
- ❑ Being bothered by unpleasant thoughts that do not make sense and keep coming back even when you try ro control them.
- ❑ Reliving past traumatic experiences through nightmares or flashbacks.
- ❑ Weighing less than others thought you should.
- ❑ Being excessively afraid of becoming fat.
- ❑ Periods of binge eating (eating excessive amounts of food in short periods of time.)
- ❑ Being afraid of being around people.
- ❑ Missing school or work because of drug or alcohol use.
- ❑ A feeling that people are taking a special notice of you.
- ❑ Receiving special messages from television, newspaper, or other unusual means.
- ❑ Feeling that people are trying to hurt you or give you a hard time.
- ❑ Feeling that either you or other people have special powers.
- ❑ Feeling that someone or something outside of yourself is controlling your thoughts or actions.
- ❑ Having thoughts that were not your own or were being put into your head.
- ❑ Seeing things that other people could not see.
- ❑ Having strange sensations in your body or skin.
- ❑ Smelling things that other people could not smell.
- ❑ Hearing voices that other people could not hear.
- ❑ Outburst of anger or violence.
- ❑ Being forewarned/ known that something would happen before it did.
- ❑ Feeling of hopelessness.
- ❑ Things happened which have special meanings only for you.
- ❑ Being in a place and having no recall of how you got there.
- ❑ Greeted by people who call you by another name and seem to know you.
- ❑ Feeling detached or separated from yourself.
- ❑ Being so involved in a daydream you couldn't tell if it was real or not.
- ❑ Thoughts of suicide.
- ❑ Thoughts of killing others.
- ❑ Bizarre or unusual experiences that you cannot explain.
- ❑ Visions.
- ❑ Head injury.
- ❑ Being arrested.
- ❑ Medical problems.
- ❑ Other: _____

_____