NORTHERN MICHIGAN PSYCHIATRIC SERVICES, PC.

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SOCIAL HISTORY QUESTIONNAIRE TO BE COMPLETED BY PARENTS

Date: _____ Person(s) completing form: [ ] Mother [ ] Father [ ] Other _____

Who referred you to Northern Michigan Psychiatric Services? _____

Child's Name: _____
Last First Middle

Birth Date: _____ Age: _____ Sex: _____ Grade: _____

Home Address: _____
Street City State Zip

Home Telephone Number: _____ Cell: _____
Area code Number Area code Number

Child's School: _____
Name Grade

_____
School District Teacher's Name

I. PRESENT HOME OF CHILD (Place a check in appropriate box):

	Adults with whom Child is living	Other adults involved with child
Natural mother	[ ] _____	[ ] _____
Natural father	[ ] _____	[ ] _____
Stepmother	[ ] _____	[ ] _____
Stepfather	[ ] _____	[ ] _____
Adoptive mother	[ ] _____	[ ] _____
Adoptive father	[ ] _____	[ ] _____
Foster mother	[ ] _____	[ ] _____
Foster father	[ ] _____	[ ] _____
Other (specify): _____	[ ] _____	[ ] _____

Please number each person with whom the child is living listed above and provide the following information about each person. Please use the pack of this page if needed.

A. Name _____ Occupation _____

Business name and telephone _____

B. Name _____ Occupation _____

Business name and telephone _____

C. Name _____ Occupation _____

Business name and telephone _____

SIBLINGS (include step-siblings):

NAME	AGE	WHERE LIVING	MALE FEMALE	MEDICAL, SCHOOL OR OTHER PROBLEMS

II. CURRENT CONCERNS:

A. Please write a description of your child's present problems.

B. When were the child's current problems first noticed?

C. Who noted the changes (i.e. teacher, doctor, parent, friends)?

D. What do you think brought about the problems?

E. What kind of help do you think your child needs?

F. Please describe your child's hobbies, special abilities, interests.

G. Are there any factors or changes in the family circumstances which may be affecting your child?

III. PRIOR SERVICES:

Please list names and addresses of all psychiatrist, psychologists, therapists, social workers, school evaluators, physicians and any other persons (as well as agencies or hospitals) who have seen or treated your child in any professional capacity. The reverse of this sheet may be used if needed to give a complete listing.

NAME: _____

ADDRESS: _____

DATES SEEN: _____

TYPE OF CONTACT (e.g. evaluation, therapy, etc.): _____

NAME: _____

ADDRESS: _____

DATES SEEN: _____

TYPE OF CONTACT (e.g. evaluation, therapy, etc.): _____

IV. CHILD'S PERSONAL HISTORY:

A. Pregnancy of mother

How many pregnancies has the birth mother of this child had? (Circle Number)

1 2 3 4 5 6 7 8 9 10 _____

Which pregnancy was this child? (Circle Number)

1 2 3 4 5 6 7 8 9 10 _____

What was the age of the birth mother at the time of this child's birth? _____

B. Please indicate the following about this pregnancy. (Circle Yes or No)

Yes No Were there any complications or medical illnesses during the pregnancy such as infection, bleeding, spotting, nausea or vomiting, physical injury, high blood pressure, high blood sugar, eclampsia, or any other? If yes, please describe: _____

_____

_____

_____

YES NO Hospitalizations during the pregnancy? If yes, please explain: _____

_____

_____

YES NO Tobacco Use? If yes, how much? _____

YES NO Alcohol consumption? If Yes, how much? _____

YES NO Prescribed Medications used (please list): _____

_____

YES NO Over-the-counter medications or supplements used (please list): _____

_____

YES NO Emotional stress? If yes, please explain: _____

_____

YES NO Was your child extremely active during pregnancy? _____

C. What were your feelings concerning the pregnancy? (planned/unplanned)

D. Characteristics of labor (please check appropriate boxes):

[ ] Spontaneous
[ ] Induced medically
[ ] Difficult or prolonged
Duration of labor _____

E. Characteristics of delivery (please check appropriate boxes):

[ ] Occurred at term
[ ] Occurred prematurely (how early?) _____
[ ] Occurred late (how late?) _____
[ ] Regular delivery [ ] with anesthesia [ ] without anesthesia
[ ] use of forceps
[ ] Caesarean section delivery
[ ] Doctor indicated child was in distress before being born
[ ] Difficult or complicated delivery (please describe): _____
_____

F. Please describe any problems your child had immediately after birth (including illness, fever, physical deformities, yellow jaundice, need for transfusion, incubator care, need for oxygen, needed lights, etc):

_____

_____

G. Please indicate birth weight: _____

H. Indicate items that characterize your child's life from birth to age 2 (check all that apply):

Temperament	**Routines**	**Behavior**	**Illness**
[ ] happy	[ ] difficulty gaining weight	[ ] too active	[ ] frequent colds or flu
[ ] easy going	[ ] resisted solid food	[ ] frequent self-rocking	[ ] food/other allergies
[ ] colicky	[ ] trouble with going to sleep or sleep routines	[ ] head banging	[ ] eczema
[ ] cried a lot		[ ] destructive of crib toys	[ ] hospitalization
[ ] rarely cried	[ ] trouble with feeding or eating routines	[ ] unusual behaviors	
[ ] angry		[ ] unable to focus	
[ ] affectionate	[ ] breast fed	[ ] extremely impulsive	
[ ] distant			
[ ] not cuddly			
[ ] didn't like to be held			

Please describe any other important characteristics of your child before age 2. _____

_____

_____

_____

I. DEVELOPMENTAL MILESTONES

If you can recall, records the age at which your child reached the following developmental milestones. If you cannot recall, check general times as compared to other children.

	Age:	**I cannot recall, but to the best of my recollection, it occurred:**		
		Early	*Normal Time*	*Late*
Smiled				
Sat without support				
Crawled				
Stood without support				
Walked without assistance				
Spoke first words besides "ma-ma" and "da-da"				
Said phrases				
Bowel trained, day				
Bowel trained, night				
Bladder trained, day				
Bladder trained, night				
Rode bicycle (without training wheels)				
Buttoned clothes				
Tied shoelaces				
Named colors				
Said alphabet in order				
Began to read				

J. COORDINATION

Rate your child on the following skills:

	Good	*Average*	*Poor*
Running			
Throwing and catching			
Tying shoelaces			
Buttoning			
Writing			
Athletic abilities			

K, COMPREHENSION AND UNDERSTANDING

1. Do you consider your child to understand directions and situations as well as other children in his or her age?
   YES NO If no, in what way? _____
   _____
2. How would you rate your child's overall level of intelligence compared to other children?
   _____ Below average _____ Average _____ Above Average

V. SCHOOL

A. Rate your child's school experiences related to academic learning:

	GOOD	AVERAGE	POOR
Nursery school			
Kindergarten			
Current grade			

B. To the best of your knowledge, at what grade level is your child functioning?

_____ Reading _____ Spelling _____ Arithmetic

C. What kind of special therapy or services is your child currently receiving in school (charter reading, resource room, special education, etc.) _____

_____

_____

D. Present class placement: _____ Regular class _____ Special class (specify) _____

E. Please described any academic school problems: _____

_____

_____

_____

F. Rate your child's school experience relate to behavior:

	GOOD	AVERAGE	POOR
Nursery school			
Kindergarten			
Current grade			

G. Describe any school behavioral problems: _____

_____

_____

_____

VI. PEER RELATIONSHIPS

[ ] How frequently does your child seek friendships with peers? NEVER SOME OFTEN TOO MUCH

[ ] How frequently is your child sought by peers for friendship? NEVER SOME OFTEN TOO MUCH

Does your child play primarily with children his or her own age? _____ younger _____ older

Describe briefly any problems your child may have with peers: _____

_____

_____

_____

VII. MEDICAL

A. Family physician _____
Name Telephone number

_____
Address

B. If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

YES NO Childhood diseases (measles, mumps, chicken pox, whooping cough, etc.) Describe any complications: _____

_____

YES NO Operations: _____

_____

YES NO Hospitalizations for illness (es): _____

_____

YES NO "Knocked out" or concussion: _____

_____

YES NO Convulsions (seizures): _____

_____

YES NO Coma: _____

_____

YES NO Meningitis or encephalitis: _____

_____

YES NO Immunization reactions: _____

_____

YES NO High fevers: _____

_____

YES NO Eye problems: _____

Last vision test: _____

YES NO Ear problems: _____

Last hearing test: _____

YES NO Accidental poisoning or ingestion: _____

_____

YES NO Sleep problems: (snoring, irregular breathing, restless) _____

_____

VIII. PRESENT MEDICAL STATUS

A. Present Height: _____ Weight: _____

Present illness (es) for which child is being treated: _____

_____

Please list ALL of your child's prescribed medications (PAST and CURRENT); the dose & how often they took them; when they were started as well as when and why they were stopped. (if none, write none)

Medication Name	*Dosage*	*Est. Start Date*	*Stopped Date*	*Reason Stopped*

Please list any vitamins, supplements, natural remedies or herbal preparations your child is taking:

_____

Any known drug allergies: _____

_____

Describe your child's appetite: _____

_____

Describe your child's sleep habits: _____

_____

B. YES NO Does your child wet or soil him/herself? If so, please describe: _____

_____

YES NO If applicable, has your daughter begun menstruation? If so; at what age? _____

Her reaction: _____

Are her periods regular? _____ Are there any problems? _____

_____

YES NO Do you have any concerns about your child's sexual behavior? If so, please describe: _____

_____

YES NO Has your child received any sex education information? If so, from whom? _____

_____

YES NO Do you have any concerns your child is using drugs or alcohol? If so, please describe: _____

_____

IX. FAMILY HISTORY:

A. MOTHER

1. Age _____
2. School: Highest grade completed _____
   Learning problems (describe) _____
   Behavior problems (describe) _____
3. Medical problems (describe) _____
   _____
4. Has mother or any of her blood relatives ever had problems similar to those of this child? If so, please describe: _____
   _____

5. Has mother or any of her blood relatives ever had:

YES NO A mental or emotional illness, psychiatric hospitalization, depression, suicide attempt, nervous breakdown, substance abuse, alcoholism, Attention Deficit Disorder, hyperactivity, learning disabilities, seen a therapist or psychiatrist? If yes, please give relation to child and describe:

_____

_____

_____

YES NO A neurological illness such as tics (sudden, involuntary movements), seizures or epilepsy, mental retardation, or any other illness that affected the brain or nervous system? _____

_____

YES NO Died suddenly of unexplained causes? _____

_____

YES NO Died at a young age of heart problems? _____

B. FATHER

1. Age _____
2. School: Highest grade completed _____
   Learning problems (describe) _____
   Behavior problems (describe) _____
3. Medical problems (describe) _____
   _____
4. Has father or any of his blood relatives ever had problems similar to those of this child? If so, please describe: _____
   _____

5. Has father or any of his blood relatives ever had:

YES NO A mental or emotional illness, psychiatric hospitalization, depression, suicide attempt, nervous breakdown, substance abuse, alcoholism, Attention Deficit Disorder, hyperactivity, learning disabilities, seen a therapist or psychiatrist? If yes, please give relation to child and describe: ___
_____

_____

_____

YES NO A neurological illness such as tics (sudden, involuntary movements), seizures or epilepsy, mental retardation, or any other illness that affected the brain or nervous system? _____
_____

YES NO Died suddenly of unexplained causes? _____

_____

YES NO Died at a young age of heart problems? _____

C. STEP-PARENT

1. School: Highest grade completed _____
   Learning problems (describe) _____
   Behavior problems (describe) _____
2. Medical problems (describe) _____
   _____
3. Has step-parent or any of his/her blood relatives ever had problems similar to those of this child? If so, please describe: _____
   _____

ADDITIONAL REMARKS:
Please use the remainder of this page or additional sheets to write any additional comments you wish to make regarding your child's difficulties.