

Fire Island School District

P.O. Box 428

Ocean Beach, New York 11770-0428

Phone: (631) 583-5626 Fax: (631) 583-5167

SOCIAL HISTORY CONFIDENTIAL

DATE: _____

NAME: _____

DOB: _____

ADDRESS: _____

PHONE NO.: Home: _____

COMPLETED BY: _____

I. HOUSEHOLD COMPOSITION:

NAME	RELATIONSHIP	AGE/DOB	OCCUPATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

II. GENERAL FAMILY INFORMATION:

- Is the child/adolescent adopted? No Yes

If yes, at what age was he/she adopted? _____

III. AGENCIES KNOWN TO FAMILY:

	<u>Contact Name</u>	<u>Contact Phone #</u>
a. Individual psychological counseling/therapy	_____	_____
b. Family counseling/therapy (parent + child)	_____	_____
c. Group counseling/therapy with other children	_____	_____
d. Hospitalization	_____	_____
e. Emergency room visits	_____	_____
f. Department of Social Services	_____	_____
g. Child Protective Services	_____	_____
h. Probation	_____	_____
i. OMRDD	_____	_____
j. Sagamore	_____	_____
k. SPOA	_____	_____
l. Outreach	_____	_____
m. Outside Agencies (Cody Center, UCPA, etc)	_____	_____

Please indicate Agency: _____

Does your child receive SSI? No Yes

Does your child receive Medicaid? No Yes

IV. EDUCATIONAL PLACEMENT HISTORY:

<u>Grade Level</u>	<u>Name of School</u>	<u>District</u>	<u>Date of Grade</u>
Preschool	_____	_____	_____
Elementary	_____	_____	_____
Middle	_____	_____	_____
Secondary	_____	_____	_____

Have there been any grades repeated? No Yes

If so, what grades? _____

V. FAMILY DYNAMICS:

1. How does your child get along with brothers and sisters? (check **all** that apply)

- | | |
|-----------------------------------|---------------------------------|
| a. _____ no real problem | d. _____ has frequent arguments |
| b. _____ avoids contact | e. _____ teases them |
| c. _____ frequent physical fights | f. _____ is teased by them |
| | g. _____ N/A, only child |

2. About how many times a week does your child do things with friends outside of the home or school? _____

Compared to others of his/her age, describe how your child:	<u>Below Average</u>	<u>Average</u>	<u>Above Average</u>
Gets along with brothers and sisters	_____	_____	_____
Gets along with other kids	_____	_____	_____
Responds to parental direction	_____	_____	_____
Plays and works by him/herself	_____	_____	_____

VI. PSYCHOSOCIAL PROFILE:

A. School, Home, and Social Functioning

1. In general, with whom does your child tend to play? (check **all** that apply)

- a. _____ children about the same age
- b. _____ much younger children
- c. _____ no preference
- d. _____ much older children
- e. _____ adults

2. Would you say your child has...(check **one** of the following)

- _____ many friends _____ a few friends _____ one friend _____ no friends

3. How does your child get along with other children? (check **all** that apply)

- a. _____ no real problems
- b. _____ avoids contact
- c. _____ is shy but finally makes friends
- d. _____ wants friends but is socially awkward
- e. _____ is very bossy and controlling
- f. _____ has frequent arguments
- g. _____ has frequent physical fights
- h. _____ teases them
- i. _____ is teased by them

4. Has your child... (check **all** that apply)

	<u>Never</u>	<u>Past Year</u>	<u>Age Began</u>
Refused to go to school	_____	_____	_____
Complained of being ill to stay home	_____	_____	_____
Been frightened/nervous about going to school	_____	_____	_____
Stayed out of school without your permission	_____	_____	_____
Been suspended or expelled from school	_____	_____	_____

5. Approximately how many days did your child miss school during the past year? (Put 0 if none)

- a. days missed because of suspension: _____
- b. days missed because he/she skipped: _____
- c. days missed because he/she was ill: _____

- B. What are your expectations for your child's future – social, vocational, academic?
(If the student is under 12, the social worker should introduce the concept of Transition Planning.)

- C. Please share any concerns you have:

VII. MEDICAL ISSUES:

- A. Child's Medical History

1. Child's birth weight: _____

2. Check **any** of the following which occurred during the pregnancy with this child:

- a. _____ severe nausea and vomiting
- b. _____ high blood pressure
- c. _____ incompatible Rh factor
- d. _____ bleeding: (_____ 1st 3 months, _____ 2nd 3 months, _____ 3rd 3 months)
- e. _____ medications during pregnancy: which? _____
- f. _____ toxemia
- g. _____ rubella, mumps
- h. _____ diabetes
- i. _____ other problems _____

3. Check **any** of the following if they occurred at or following the delivery of the child:

- a. _____ premature delivery (more than 2 weeks early)
- b. _____ late delivery (more than 2 weeks)
- c. _____ cesarean section
- d. _____ breech delivery (feet or buttocks first)
- e. _____ infant had cord around neck
- f. _____ infant was blue at birth
- g. _____ infant required oxygen
- h. _____ infant required blood transfusion
- i. _____ infant was placed in an incubator
- j. _____ other problems _____

2. Family Medical History

Please check **any** family members with a history of difficulties in the areas noted:

<u>RELATIONSHIP</u>	<u>CHRONIC MEDICAL PROBLEMS</u>	<u>NEUROLOGIC DISORDERS</u>	<u>SEIZURE DISORDER</u>	<u>THYROID DISORDER</u>	<u>MENTAL RETARDATION</u>	<u>LEARNING DISABILITY</u>	<u>AUTISM SPECTRUM</u>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VIII. OTHER:

Signature: _____

Date: _____