Silver Psychiatric Services

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SOCIAL AND DEVELOPMENTAL HISTORY

Completed by: Mother Father Legal Guardian _____

Other (explain relationship to patient) _____

Referring Person: _____ Phone: _____

Identification:

Patient Name: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____

Date of Birth: _____ Age: _____ Religion: _____ Race: _____

School Information:

School: _____ Grade: _____

Regular Ed: _____ Special Ed (type) _____

Special Services (check all that apply):

- ☐ Resource Room (%time) _____
- ☐ Speech/Language
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Adaptive Physical Education
- ☐ Advanced placement
- ☐ Other _____

	Name	Phone
Guidance Counselor:	_____	_____
School Psychologist:	_____	_____
Teacher:	_____	_____
Other:	_____	_____
Primary Care Doctor:	_____	_____
Mental Health Caregiver(s):	_____	_____
(If applicable)	_____	_____

Social Service Agency (if applicable)

Name: _____

Service: _____

Contact person: _____ Phone: _____

Referring Person(s): _____

Other Information:

Mother:

Name: _____ Age: _____ DOB: _____

Address (if different): _____

Phone – Home: _____ Work: _____ Cell: _____

Place of Birth: _____ Social Security # _____

Education: _____

Occupation: _____ Place of Business: _____

How long at present job: _____

Insurance policy name: _____ Ins. Policy No.: _____

Religion: _____ Race: _____

Please Check: ☐Biological Parent ☐ Adoptive Parent ☐ Foster Parent ☐ Step-parent

Emergency contact: _____ Phone: _____

Father:

Name: _____ Age: _____ DOB: _____

Address (if different): _____

Phone – Home: _____ Work: _____ Cell: _____

Place of Birth: _____ Social Security # _____

Education: _____

Occupation: _____ Place of Business: _____

How long at present job: _____

Insurance policy name: _____ Ins. Policy No.: _____

Religion: _____ Race: _____

Please Check: ☐Biological Parent ☐ Adoptive Parent ☐ Foster Parent ☐ Step-parent

Emergency contact: _____ Phone: _____

Parents/Guardian:

Are parents married? ☐ Yes ☐ No Date of Marriage: _____

Are parents living together? ☐ Yes ☐ No

If no, are parents: ☐ Separated Date of Separation: _____

☐ Divorced Date of Divorce: _____

☐ Deceased Date: _____

Who is the legal custodian?

Name: _____

Relationship to parent: _____

Address: _____

_____

Phone: _____

Reason for seeking treatment for your child:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Major changes or stressors:

Have there been or are there currently any major changes or stresses in the family where your child was brought? ☐ Yes ☐ No

If yes please mark all that apply:

In the past (More than 1 yr ago)	Current (1 yr ago or less):	**FAMILY**
_____	_____	1. Drinking/drug problems
_____	_____	2. Arguments between parents
_____	_____	3. Physical confrontation between parents
_____	_____	4. Separation or divorce of parents
_____	_____	5. Remarriage of parent(s)
_____	_____	6. Separation from sibling(s)
_____	_____	7. Separation from other family members
_____	_____	8. Separation from significant non-family members
_____	_____	9. Medical illness in family
_____	_____	10. Medical hospitalization of a parent
_____	_____	11. Psychiatric hospitalization in family
_____	_____	12. Death in family
_____	_____	13. Incestuous behavior in family
_____	_____	14. Financial problems in family
_____	_____	15. Legal problems in family
_____	_____	16. Frequent moves
_____	_____	17. Job changes
_____	_____	18. Frequent physical punishments of child
_____	_____	19. Other family problems
_____	_____	20. Other traumatic situations

In the past (More than 1 yr ago)	Current (1 yr ago or less):	**CHILD**
_____	_____	1. Drinking/drug use
_____	_____	2. Arguments with parents
_____	_____	3. Self-harm (cutting, burning)
_____	_____	4. Sexual behaviours
_____	_____	5. Restricting food intake
_____	_____	6. Excessive food intake
_____	_____	7. Truancy from school
_____	_____	8. Conflicts with teacher(s)
_____	_____	9. Arguments/fights with peers
_____	_____	10. Physical confrontation with parents

Social History:

List **all** of the family and significant others in the household:

Name	Relationship	Age	Occupation	Quality of Relationship (good, poor, conflicted)
1.				
2.				
3.				
4.				
5.				

List the family and significant others **not** in the home

Name	Relationship	Age	Geographic Location	Phone Number
1.				
2.				
3.				
4.				
5.				

Developmental History:

Duration of pregnancy (in weeks): _____

Labor: Duration: _____ Any problems, specify: _____

_____

Delivery: ☐ Vaginal ☐ C-section Any problems, specify: _____

_____

New born period: ☐ Normal ☐ Any problems, specify (oxygen, incubator, infection, jaundice requiring treatment, breathing difficulty, etc.): _____

_____

First year – Temperament

- ☐ Easy baby
- ☐ Slow to warm up (give example) _____
- ☐ Difficult baby (give examples) _____

  Eating habits (normal or abnormal) _____

  Sleeping habits (normal or abnormal _____
- ☐ Colic (if yes, for how long) _____

  Sat up at what age _____

  Walked at what age _____

Other Milestones:

First words at age _____ Three word sentence at age _____

Toilet training at age – Bladder _____ Bowel_____

Any current problem with wetting or soiling (specify)? _____

Adolescent Development:

Age at first menses _____ Last menstrual period _____

Sexually active ☐ Yes ☐ No ☐ Unknown

Peer relationships: ☐ Satisfactory ☐ Unsatisfactory

Explain: _____

Substance Use: (circle)

			Uses per week	Date of last Use
No	Yes	Alcohol		
No	Yes	Cocaine		
No	Yes	Marijuana		
No	Yes	Opioids		
No	Yes	Sedative		
No	Yes	Ecstasy		
No	Yes	Nicotine		
No	Yes	Caffeine		
No	Yes	Others		

School History:

Attended Preschool ☐ Yes ☐ No
Adjustment ☐ Satisfactory ☐ Unsatisfactory, specify _____
Academic Progress ☐ Satisfactory ☐ Unsatisfactory, specify _____
Social Progress ☐ Satisfactory ☐ Unsatisfactory, specify _____

	Name of School	Any difficulties, specify
Kindergarten	_____	_____
	_____	_____
Elementary Grades	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
Junior High/Middle school	_____	_____
	_____	_____
	_____	_____
	_____	_____
High School	_____	_____
	_____	_____
	_____	_____
	_____	_____

Legal problems: ☐ No ☐ Yes, specify _____

Family History of Emotional Disorders:

	Relationship to patient	**Treated/Untreated**
Schizophrenia	_____	_____
Depression	_____	_____
Manic Depression (Bipolar Disorder)	_____	_____
Anxiety	_____	_____
Panic Attacks	_____	_____
Obsessive –Compulsive Disorder	_____	_____
Substance Abuse/Dependence	_____	_____
Alcohol Abuse/Dependence	_____	_____
Anger Problems	_____	_____
Attention Deficit Hyperactivity	_____	_____
Behavior/Conduct Problems	_____	_____
Learning Problems	_____	_____
Tics	_____	_____
Mental Retardation	_____	_____
Suicide Attempts	_____	_____
Completed Suicide	_____	_____
Victim of Trauma (specify)	_____	_____
Eating Disorders	_____	_____
Gambling	_____	_____

Previous Psychological/Psychiatric Treatment:

Have you ever received psychiatric or psychological treatment of any kind before? ☐ Yes ☐ No

If you checked yes to the above question please answer the following:

What type of care did you receive? ☐ Inpatient (hospital) ☐ Outpatient ☐ Both

Where were you in treatment?

_____

_____

When were you in treatment? _____

How long were you in treatment? _____

Who was your therapist or doctor? _____

_____

Did your doctor prescribe Medicine at that time? ☐ Yes ☐ No ☐ Not applicable

If yes what was prescribed (include dosage, reaction, benefit if known)

_____

_____

(Continued previous medication trials, doses, reactions, benefit)

_____
_____
_____
_____

Current Medications: (please list all medications currently being taken including over the counter meds/vitamins)

Name of Medication	How many MG or pills	Route (i.e. by mouth)	Date Began	Reason for Medication	Response

Medical History:

Date of most Recent Physical Exam: _____ Results: _____

Please provide the name and address of your physician or medical clinic: _____

Name: _____ Phone: _____

Address: _____

_____

Are you now receiving treatment? _____

List below serious illnesses, accidents, or operations which you have had. Give the date of the illness or injury, and if you were hospitalized, give the name of the hospital, approximate length of stay, and the attending physician.

_____
_____
_____

Allergies: _____

Activities of Daily Living (List any problems or need for assistance with the following):

	Independent	Partial Assistance	Total Assistance	Comments
Eating				
Sleeping				
Dressing				
Ambulation				
Hygiene-Bathing/Showering				
Elimination-Toileting				

Reviewed by: _____ **Date:** _____