Please have family member, or someone with extensive knowledge
of the referral complete this questionnaire prior to Admission.

GUARDIAN SOCIAL & MEDICAL HISTORY QUESTIONNAIRE

DATE: _____ **COMPLETED BY**: _____

The purpose of this form is to obtain a social and medical history of your child's life. The information that you are able to give us will aid us in coming to a better understanding of your child's present problems so that we can be of help to you and him/her. Please provide information regarding all parental figures.

Information will be treated as privileged and confidential and will not be released to others without you written permission or request.

Child's full name: _____Nickname: _____
Street address: _____Phone: _____
City, State, Zip: _____
Birthdate: _____Sex: _____
Current School: _____Grade: _____
Social Security #: _____

Who is referring child: _____

Father's name: _____ Birthdate: _____
Home Address: _____
Home Phone: _____Work Phone: _____
Education: _____Occupation: _____
Work Address: _____
If deceased, date and cause of death: _____

Mother's name: _____ Birthdate: _____
Home Address: _____
Home Phone: _____Work Phone: _____
Education: _____Occupation: _____
Work Address: _____
If deceased, date and cause of death: _____

Who has legal custody of child? _____

If child is adopted, at what age? _____

At what age was child informed of and what was child's reaction to adoption? _____

_____

_____

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REASON FOR ADMISSION / WHY ARE YOU BEING ADMITTED TODAY? (Chief Complaint)

PATIENT REPORT:

_____

_____

_____

_____

_____

PARENT REPORT:

_____

_____

_____

_____

_____

HOW LONG HAS THIS BEEN A PROBLEM (ONSET, INTENSITY, DURATION, AND FREQUENCY)? (History of Present Illness)

PATIENT REPORT:

_____

_____

_____

_____

_____

PARENT REPORT:

_____

_____

_____

_____

_____

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PREVIOUS PSYCHIATRIC HOSPITALIZATION/PLACEMENTS (2 years minimum)

1. PLACEMENT DATE(S) REASON FOR PLACEMENT

_____ _____ _____

RESPONSE TO TREATMENT (did the patient go home, on to higher level of care?)

_____

2. PLACEMENT DATE(S) REASON FOR PLACEMENT

_____ _____ _____

RESPONSE TO TREATMENT (did the patient go home, on to higher level of care?)

_____

3. PLACEMENT DATE(S) REASON FOR PLACEMENT

_____ _____ _____

RESPONSE TO TREATMENT (did the patient go home, on to higher level of care?)

_____

DEVELOPMENTAL HISTORY *(family of origin Information / dynamics, childhood / school history, significant losses)*

Were there birth complications? ☐ **No** ☐ **Yes, Please explain**

_____

_____

_____

_____

_____

_____

_____

_____

Were Developmental Milestones met? ☐ **Yes** ☐ **No, Please explain**

_____

_____

_____

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Were there any other concerns or incidents during developmental years? (Head trauma, attachment issues or concerns…) ☐ **No** ☐ **Yes, Please explain**

_____

_____

_____

_____

_____

FAMILY/SOCIAL

RELIGIOUS / CULTURAL / ETHNIC BACKGROUND

Are there religious beliefs or ethnic/cultural considerations that are important to you? If so, please describe

_____

_____

_____

_____

How would your family FINANCIAL STATUS be described?

☐ Low Socioeconomic ☐ Middle Socioeconomic ☐ Upper Socioeconomic

CURRENT FAMILY ENVIRONMENT / LIVING SITUATION *(members, stressors, effects of patient's condition on family and vice versa)*

Name	Relation	Age	Currently in the home?	IF not, where do they reside?
_____	_____	_____	☐ **Yes**	☐ **No,** _____
_____	_____	_____	☐ **Yes**	☐ **No,** _____
_____	_____	_____	☐ **Yes**	☐ **No,** _____
_____	_____	_____	☐ **Yes**	☐ **No,** _____
_____	_____	_____	☐ **Yes**	☐ **No,** _____

Is there a family history of PSYCHIATRIC or substance abuse? ☐ **No** ☐ **Yes, please describe**

Who:_____ When:_____

Reason:_____

Who:_____ When:_____

Reason:_____

Who:_____ When:_____

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Reason:_____

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Can you describe the PATIENT'S RELATIONSHIP WITH FAMILY MEMBERS?

WITH PARENT/GUARDIAN:

_____

_____

WITH SIBLINGS:

_____

_____

WITH EXTENDED FAMILY:

_____

_____

Does the patient have an active peer group? ☐ No ☐ Yes, complete below

Fighting/Conflicts:

_____

_____

_____

Criminal/Deviant Behavior (Drug Use):

_____

_____

_____

Sexual Misconduct:

_____

_____

_____

Other:

_____

_____

_____

Are there problems with interactions with SIGNIFICANT ADULTS (neighbors, adult friends)/Adults in authority (teachers, law enforcement, clergy)?

_____

_____

_____

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DRUG ABUSE HISTORY / TREATMENT

Has the patient ever used or have been suspected of using/abusing drugs or alcohol?

☐ No ☐ **If Yes,** Describe type of drug, frequency of use, treatment, and outcome

_____

_____

_____

_____

___

LEGAL HISTORY / CURRENT STATUS

Have there been legal issues in the patient's history?

☐ Patient denies history of legal problems

☐ If Yes, Please describe and include any probation officer contact information

_____

_____

_____

_____

___

SCHOOL / VOCATIONAL HISTORY

CURRENT GRADE LEVEL: _____ Average grade in most subjects _____

LEVEL OF FUNCTIONING: ☐ at age level ☐ above age level ☐ below age level

SCHOOL: ☐ public ☐ private ☐ home schooled Name of school _____

PATIENT'S VIEW OF SCHOOL PERFORMANCE:

_____

_____

_____

_____

___

HISTORY OF SCHOOL PROBLEMS

☐ Truancy	☐ fighting	☐ difficulty concentrating	☐ learning problems
☐ Expulsion	☐ disruptive	☐ failing grades	☐ special education
☐ Suspension	☐ lack of interest	☐ repeated grade	☐ math problems
			☐ Reading problems

LEARNING / EDUCATIONAL HISTORY:

☐ Reports no special needs ☐ special education ☐ honors classes

Barriers to learning: ☐ low IQ ☐ language

☐ Other _____

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EMPLOYMENT HISTORY

☐ Minor, does not work
☐ Minor but works as a _____ has had job for _____ months

PATIENT STRENGTHS AND NEEDS

Strengths

☐ support of family/friends
☐ insight into problems
☐ capable of independent living
☐ leisure interest skills
☐ sense of humor
☐ good physical health
☐ motivated for treatment
☐ community support network
☐ education - motivated
☐ positive family relationships
☐ intelligent
☐ motivated
☐ leader
☐ **other** _____

Needs

☐ lack of family/friends
☐ lack of insight
☐ unstable living situation
☐ recent loss
☐ legal problems
☐ academic problems
☐ history of abuse
☐ poor social skills
☐ poor self-control
☐ special education needs
☐ medical problems
☐ cognitive deficits
☐ though disturbance
☐ **other** _____

HEALTH & MEDCIAL

ALLERGIES AND TYPE OF REACTION

Drugs _____ **Food** _____ **Other** _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

CURRENT MEDICATIONS/RECONCILIATON

Medications include Psychiatric, Medical, OTC Drugs, Vitamins, Herbals, Topicals, Inhalers				
Current Medications	**Dose**	**Frequency**	**Route**	**Last dose given**

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PAST MEDICATIONS USED

_____

_____

_____

_____

_____

_____

Medical Conditions (*Include any hospitalizations, chronic disease, surgeries, and injuries)*

☐ Asthma	☐ Ulcers	☐ _____
☐ Anemia	☐ UTI	☐ _____
☐ Diabetes	☐ URI	☐ _____
☐ Seizures	☐ Pregnancy	☐ _____
☐ TB	☐ _____	☐ _____

Hospitalizations / Surgeries

☐ No ☐ Yes (Detail) _____

_____

Have you been around anyone who was sick in the past 3 weeks?

☐ No ☐ Yes (Detail) _____

_____

Dental

Date of last dental exam: _____ **Braces** ☐ No ☐ Yes, in place for _____ months

Vision/Hearing

Vision impaired ☐ No ☐ Yes (explain) _____ **With patient** ☐ Yes ☐ No
☐ Glasses ☐ Contacts

Hearing impaired ☐ No ☐ Yes (explain) _____ **With patient** ☐ Yes ☐ No
Hearing aid ☐ Yes ☐ No

Other communication devices (Specify)

_____

Neurological

History of problems ☐ No ☐ Yes (mark all that apply)
☐ Headaches ☐ Tremors _____ ☐ Numbness_____

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☐ Epilepsy (type) _____ Age at onset ____ Date last seizure _____
☐ Fainting
☐ Other (specify) _____

Cardiovascular

History of problems ☐ No ☐ Yes (mark all that apply)
☐ Chest pain ☐ Hypertension ☐ Hypotension ☐ Murmur
☐ Palpitations
☐ Other known heart condition _____
Age at onset _____

Respiratory

History of problems ☐ No ☐ Yes (mark all that apply)
☐ Asthma ☐ Persistent cough ☐ Shortness of breath ☐ Sinusitis ☐ URI
☐ Nose bleeds ☐ Nasal allergies ☐ Deviated septum ☐ Sore throat ☐ TB

Muscular

History of problems ☐ No ☐ Yes (mark all that apply)
☐ Joint pain ☐ Muscle Weakness ☐ Impaired Mobility
☐ Uses assist devices to ambulate ☐ Other _____

Gastro-Intestinal

History of problems ☐ No ☐ Yes (mark all that apply)
☐ Frequency within normal limits ☐ Ulcers ☐ Encopresis
☐ Constipation ☐ Diarrhea ☐ Bowel incontinence
Comments _____

Genito-Urinary

History of problems ☐ No ☐ Yes (mark all that apply)
☐ Frequency within normal limits ☐ Incontinence ☐ Painful urination
☐ Frequent urination ☐ Enuresis ☐ Discharge
Comments _____

Gynecological

☐ N/A ☐ No history of problems
Menses regular ☐ Yes ☐ No (explain) _____ Date of last menstrual period _____
Possibility of pregnancy? ☐ Yes ☐ No Possibility of STD? ☐ Yes ☐ No
Date of last exam _____ Comments _____

Sleep Pattern

Difficulties with sleeps ☐ No ☐ Yes (mark all that apply)
☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Nightmares
☐ Midnight awakening ☐ Early morning awakening ☐ Sleep-wake cycle
☐ Other _____

SKIN ASSESSMENT

History of problems ☐ No ☐ Yes (mark all that apply)

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☐ Acne ☐ Jaundice ☐ Skin eruptions ☐ Cyanosis
☐ Other _____

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Medical History of Child

IMMUNIZATION OR BOOSTER STATUS (Please bring complete records with you)

Immunization	Completed	Immunization	Completed
Diphtheria	☐	Measles	☐
Tetanus	☐	Polio	☐
Whooping Cough	☐	Rubella	☐

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