Reevaluation Social History Questionnaire

Confidential

Directions: To the best of your ability, please answer all the questions. If you need assistance, please call the Behavioral Health Department at (585) 383-2261.

Student's Name: _____ Date: _____

Address: _____ Gender: ☐ F ☐ M

_____ Current School: _____

Birthdate: _____ Age: _____ Grade Level: _____

Primary Language: _____ District: _____

Person Answering Questions:

Name: _____ Relationship to Student: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____

Family:

Guardian's Name: _____ Relationship to Student: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____

Occupation: _____ Employer: _____

Primary/Secondary Languages: _____

Does this child have other parents/stepparent(s)? ☐ Yes ☐ No

If yes, please provide the following information.

Name: _____ ☐ Mother ☐ Stepmother

Address: _____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____

Occupation: _____ Employer: _____

Primary/Secondary Languages:

Name: _____ ☐ Mother ☐ Stepmother

Address: _____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____

Occupation: _____ Employer: _____

Primary/Secondary Languages: _____

Primary Caregiver(s):

With what adult(s) does this student live? _____

How long in current living situation? _____

Please provide the following information about caregiver(s) if not given previously.

Name: _____ Relationship to Student: _____

Agency: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

Childcare:

If primary caregivers work outside the home who cares for this student when caregivers are working? _____

Siblings:

Please list all siblings and anyone else living with the family.

Name	Age	Gender	Relationship to Student	Living at home?

How does this student along with siblings? _____

Family Relationships:

What do you enjoy most about this student? _____

_____

_____

What concerns you the most about this student? _____

_____

Recreation/Interests:

What activities does this student enjoy?

At home? _____

At school? _____

In the community? _____

Friendships:

Please indicate how this child relates to other children. Check one.

Relates well with other children. ☐ Yes ☐ No

Fights frequently with playmates. ☐ Yes ☐ No

Makes friends easily. ☐ Yes ☐ No

Prefers to play alone. ☐ Yes ☐ No

Comments? _____

Behavior/Temperament

Is easily over stimulated in play.	☐ Yes	☐ No
Demonstrates good self-control.	☐ Yes	☐ No
Has a short attention span.	☐ Yes	☐ No
Seems overly energetic.	☐ Yes	☐ No
Takes problems in stride.	☐ Yes	☐ No
Seems happy most of the time.	☐ Yes	☐ No
Seems uncomfortable meeting new people.	☐ Yes	☐ No
Demonstrates affection.	☐ Yes	☐ No
Requires a lot of parental attention.	☐ Yes	☐ No
Able to calm self when upset.	☐ Yes	☐ No
Has fears.	☐ Yes	☐ No

If yes, please describe. _____

Do you have concerns about this student's behavior or emotions? _____

_____

Student's Development:

Were there any problems during pregnancy, labor, or delivery? ☐ Yes ☐ No

If yes, please describe: _____

_____

Is this student toilet trained?

Home: Bowel - ☐ Yes ☐ No Bladder - ☐ Yes ☐ No Not Yet ☐

School: Bowel - ☐ Yes ☐ No Bladder - ☐ Yes ☐ No Not Yet ☐

Are there any eating concerns (e.g. special feeding needs, eating disorder, etc.)?

☐ Yes ☐ No

If yes, please describe: _____

_____

Are there any sleeping concerns (e.g. bed wetting, nightmares, difficulty sleeping)?

☐ Yes ☐ No

If yes, please describe: _____

_____

Outside Providers (Contact information if applicable):

	Name	Address/Agency	Phone	FAX
Primary Physician:				
Therapist:				
Psychiatrist:				
Case Manager/ Service Coordinator:				

Specialist (e.g. development pediatrician, behavioral specialist, etc.) _____

_____

Type of Medical Insurance: _____

Is this student currently receiving any ongoing medical treatment? ☐ Yes ☐ No

If yes, please describe: _____

_____

Have there been any significant losses or changes in this student's life during the past three years (e.g. deaths, separations, divorce, illness, moves, etc.)? ☐ Yes ☐ No

Comments? _____

_____

Do you have concerns that this student engages in any of the following behaviors?

Smokes cigarettes or e-cigs	☐ Yes	☐ No	Chews tobacco	☐ Yes	☐ No
Inhales toxic substances	☐ Yes	☐ No	Drinks beer, wine, liquor	☐ Yes	☐ No
Use illegal drugs (e.g., marijuana, cocaine)				☐ Yes	☐ No

Academics:

Schools this student previously attended	Grades	Special Class Placement?

Please describe this student's experience with school.

Is easily over stimulated in play.	☐ Yes	☐ No
Has difficulty with reading.	☐ Yes	☐ No
Gets good grades.	☐ Yes	☐ No
Is frequently absent.	☐ Yes	☐ No
Has difficulty with math.	☐ Yes	☐ No
Looks forward to an academic challenge.	☐ Yes	☐ No
Has been retained a grade.	☐ Yes	☐ No
Is fearful of school.	☐ Yes	☐ No
Gets involved in extracurricular activities, clubs, and/or special projects.	☐ Yes	☐ No

If this student is age 14 or over what kinds (if any) future plans/goals do they have?

_____

_____

What goals or outcomes would you like to see for this student (e.g. type of Diploma, etc.)?

_____

_____

Are you satisfied with this student's current educational placement? ☐ Yes ☐ No

Please use the space below for any additional comments: _____

_____

_____