Putnam Valley Central School District
171 Oscawana Lake Road
Putnam Valley, NY 10579

Social History Summary

Identifiers

Child's Name: _____ DOB: _____ Sex: M F Age:_____

Nick Name: _____Grade: _____ Teacher: _____

Address: _____

Support Staff Involved with Student (name/ position): _____

Language Spoken at Home/Dominant Language: _____

Parent/Caregiver Identifiers

Caregiver Name: _____Caregiver Name: _____

DOB: _____ DOB: _____

Relation: _____Relation: _____

Address: _____Address: _____

Phone: (h)_____ Phone: (h)_____

Phone: (w) _____Phone: (w) _____

Phone: (c) _____ Phone: (c) _____

Level of Education: _____Level of Ed: _____

Occupation: _____Occupation: _____

Employer: _____Employer: _____

Other Caregivers Living in Home (name, relationship): _____

Is your child in Day Care? Y N

After School Care? Y N

Name: _____

Location: _____

Hours: _____

Divorce/Separation

When Occurred: _____

Custody Arrangement: _____

_____

Is this arrangement consistent? Y N

Remarriage or significant other? Y N

Mom Dad

When?_____When? _____

Other adult's name: _____ Other adult's name: _____

Status of parent relationship: _____

_____

Adjustment Issues: _____

_____

_____

Foster Care

When? _____ Age: _____ Length of time: _____

Kinship Placement? Y N Relation: _____

Previous Placements: _____

Reason for Placement: _____

_____

Biological Parent Information (if currently in foster care):

_____

_____

_____

Agency Name/Phone: _____

Caseworker name: _____

Plan for adoption? Y N

Presenting Problem

What has lead you to seek assistance for your child?

_____

_____

_____

Date of awareness: _____

Onset sudden or gradual?_____

Any recent deterioration?

_____

_____

What services are you seeking for your child?

_____

Residence

House Apartment Shelter Number of bedrooms: _____

Shares a room? Y N With whom: _____

How long at residence? _____

Previous residences?

_____

_____

Opportunities for play with other children? _____

Siblings

Name DOB Relation Grade School LAH?

_____

_____

_____

_____

_____

_____

Sibling relationships:

_____

_____

_____

_____

Familial History:

Check all that apply

Alcohol Abuse	Drug Abuse	Depression
Anxiety	Other Mental Illness	Traumatic Event
Traumatic Death	Emotional Abuse	Physical Abuse
Sexual Abuse	Speech Impairment	Learning Difficulties
Special Education	Behavioral Issues	Retention
Attentional Difficulty	Hyperactivity	

Notes:

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Agency Involvement

Agency Name/Phone: _____

Agency Name/Phone: _____

Agency Name/Phone: _____

Assessment Name	**Date/Agency**	**Results**

Counseling Agency	**Family member**	**Dates**	**Counselor**

Satisfaction with counseling: _____

Birth/Gestational History

Pregnancy: Pre-Natal Care Y N Premature Y N #weeks, _____
Complications (check all applicable):

Bleeding (1st, 2nd, 3rd)	Gained 30+ pounds	Gained <15 lbs.
Toxemia	Frequent vomiting	Injury
Smoking	Drug Use	Alcohol use
Infections	Labor > 12 hrs.	Anemia
High Blood Pressure	Pre-eclampsia	Illness
Hospitalization	Miscarriage	Medication use

Notes:

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Labor/Delivery (check all applicable)

Anesthesia	General	Labor<2 hrs	Breech
Forceps	Cesarean	Birth weight _____	

Post-partum depression: Y N Breast Fed Bottle Fed

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Infant/Newbom Complications (check all applicable)

Cord around neck	Injury During Birth	Trouble Breathing	Jaundice
Cyanosis	Multiple	Infection	Seizures
Diarrhea	Oxygen	Gagged often	Vomiting
Heart defect	Other defect	Trouble sucking	Jittery
Incubator	>7 days in hospital	X-ray of head	

Medications:

_____

_____

_____

_____

Notes: _____

_____

_____

_____

Child Development

Milestones (approximate age):

Sat without help _____ Crawled _____ Walked _____

Walked Stairs _____ 1st word _____

2-3 word sentences _____

Bladder trained _____

Bowel trained _____

Notes:

_____

_____

_____

Developmental Issues (check all applicable)

Bed wetting/soiling	Walking difficulty	Unclear speech	
Under/over weight	Sleeping issues		
Eating issues	Colic	Shyness	
Difficulty learning to:	skip	Ride a bike	throw/catch	Keep a schedule
School refusal	Problems changing routine		

Excitability	Overreaction to sights/sounds/taste/touch	
Desire to be held frequently	Difficulty being consoled	Temper tantrums
Irritability	Yells a lot	Head banging
Rocking	Self-destructive behavior	Poor eye contact
Failure to show affection	Odd sounds/ grunts	Jerking arms/head
Eating non-foods	Constipation	Stomach aches
Frequent naps	Heavy sleep	Cries often/ easily

Notes:

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Medical History

Pediatrician Name/Phone: _____

Last physical date: _____

Hearing Exam Date/Results: _____

Eye Exam Date: _____ Glasses: Y N

Medications:

_____

_____

_____

_____

Health Issues (check all applicable):

Ear infection	Rashes	Meningitis	Seizures
High fever	Pneumonia	Asthma	Bowel problems

Ear/eye issues	Head injury	Allergies	Anemia
Lead poisoning	Other poisoning		Heart problems
Kidney/urinary	Measles/M/R/Chicken Pox		Neurological problems

Hospitalizations: Dates

Date:_____HowLong:_____

Date:_____HowLong:_____

Date:_____HowLong:_____

Date:_____HowLong:_____

Notes:

_____

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Family Health History

Check all that apply

Cancer	Cystic Fibrosis	Diabetes
MS	Heart Disease	High BP
Kidney Disease	Migraines	Stroke
Physical Handicap	Tuberculosis	Alzheimers
Parkinsons	Sickle-cell	Tay-Sachs
Tourette's	Birthdefed	CP
MR	LD	Allergies
Behavior disorder	Speech delays	Anxiety
Head injury	Other	

Notes:

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Educational History:

School Grade Time attended Services received

_____

_____

_____

_____

Adjustment issues: (When, interventions)

_____

_____

_____

_____

Caregiver assessment of academic learning: **below** / above/ **at** grade level

Grade repeated: Y N When: _____ _

Current areas of difficulty: reading / math/ writing/ behavior/socialization

Caregiver's perception of child's feelings about school:

_____

_____

_____

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Notes:

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Home Behavior

Temperament (check all applicable)

Overstimulated in play	Short attention span	Irritable
Depressed mood	Withholds affection	Fearful
Impulsive	Overly energetic	Shy
Places him/herself in dangerous situations		
Easily distracted	Talks excessively	Transition issues
Interrupts	Poor judgment	Isolated
Frustrates easily	Difficulty playing quietly	Organizational issues
Driven by a motor	Excessive accidents	Poor memory
Neat/ orderly	Lies	Destructive
Bullying	Leader/follower	Hides feelings
Shifts between activities quickly		Reactive
Doesn't learn from experience		

Notes: _____

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_____

How do you reward your child? _____

How do you discipline your child? _____

Who usually disciplines? _____

Do caretakers agree on discipline? _____

Does your child complete chores? _____

Adaptive Skills (check all applicable)

Dresses self	Gives gifts to others	Can get help when lost
Says please/thank you	Helps with houseworkTable manners	
Tells time	Bathes self	

_____

_____

_____

_____

Peer Relationships (check all applicable)

Difficulty relating to other children	Prefers to play alone	Bossy
Prefers friends that are:	older/younger/	same sex/ opposite sex
Role in group games:	leader/ follower/ aggressor	

Strengths

Hobbies and Interests:

_____

_____

Area of Greatest Accomplishment: _____

What does he/she like doing most?

_____

_____

_____

What you like about your child?

_____

_____

_____

_____

_____

_____

_____ _____

Informant Social Worker/Psychologist

_____ _____

Informant Interpreter

_____

Date

Emergency Contact Name and Phone: _____

Notes:

_____

_____

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