Office of Pupil Personnel and Student Services
Putnam Valley Central School District
146 Peekskill Hollow Road
Putnam Valley, NY 10579

Social History Summary

Identifiers ***Date:*** _____

Child's Name: _____ DOB: _____ Sex: _____ Age: _____
Nick Name: _____ Grade: _____ Teacher: _____
Address: _____
Support Staff Involved with Student (Name/Position): _____
Language Spoken at Home/Dominant Language: _____

Parent/Caregiver Identifiers

Caregiver Name: _____
DOB: _____
Relation: _____
Address: _____
Phone: (H) _____
Phone: (W) _____
Phone: (C) _____
Level of Education: _____
Occupation: _____
Employer: _____

Caregiver Name: _____
DOB: _____
Relation: _____
Address: _____
Phone: (H) _____
Phone: (W) _____
Phone: (C) _____
Level of Education: _____
Occupation: _____
Employer: _____

Other Caregivers Living in Home (Name, Relationship): _____
_____

Is your child in Day Care? ☐ Yes ☐ No
Name: _____
Location: _____
Hours: _____

Is your child in After School Care? ? ☐ Yes ☐ No
Name: _____
Location: _____
Hours: _____

Divorce/Separation- Mother

When Occurred: _____
Custody Arrangement: _____
Is this arrangement consistent? _____ Explain: _____
Remarriage or significant other? _____
Mother: _____
When? _____
Other Adult's Name: _____
Status of parent relationship: _____
Adjustment Issues: _____

Divorce/Separation- Father

When Occurred: _____
Custody Arrangement: _____
Is this arrangement consistent? _____ Explain: _____
Remarriage or significant other? _____
Father: _____

When? _____
Other Adult's Name: _____
Status of parent relationship: _____
Adjustment Issues: _____

Foster Care

When? _____ Age: _____ Length of Time: _____
Kinship Placement: _____ Relationship: _____
Previous Placements: _____
Reason for Placement: _____
Biological Parent Information (if currently in foster care): _____
Agency Name/Phone: _____
Caseworker name: _____
Plan for adoption? _____ Explain: _____

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:

Type: _____ Number of Bedrooms: _____

How long at residence? _____
Previous residences? _____
Opportunities for play with other children? _____

Siblings

Name	DOB	Relation	Grade	School	Lives At Home?

Sibling relationships: _____

Familial History:

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

Notes: _____

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: _____ Premature: _____ # of weeks: _____

Complications:

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

Notes: _____

Labor/Delivery

- ☐ Anesthesia
- ☐ Breech
- ☐ General
- ☐ Forceps
- ☐ Labor<2 hrs.
- ☐ Cesarean

Birth weight

Post-Partum Depression: _____

Infant/Newborn Complications

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

Medications: _____

Notes: _____

Child Development

Milestones (approximate age):

Crawled _____
Sat without help _____
First word _____
2-3 word sentences _____
Walked _____
Bladder trained _____
Bowel trained _____
Walked stairs _____

Notes: _____

Developmental/Behavioral Concerns:

Difficulty learning to:

☐ Skip ☐ Ride a bike ☐ Throw/Catch
☐ Keep a schedule

Areas of concern:

☐ Bedwetting/Soiling
☐ Colic
☐ Constipation
☐ Cries often/easily
☐ Desire to be held frequently
☐ Difficulty being consoled
☐ Eating issues
☐ Eating non-foods
☐ Excitability
☐ Failure to show affection
☐ Frequent naps
☐ Head Banging
☐ Heavy sleep
☐ Irritability
☐ Jerking arms/head
☐ Odd sounds/grunts
☐ Overreaction to sights, sounds, taste & touch
☐ Poor Eye Contact
☐ Problems changing routine
☐ Rocking
☐ School refusal
☐ Self Destructive Behavior
☐ Shyness
☐ Sleeping issues
☐ Stomach aches
☐ Temper tantrums
☐ Unclear speech
☐ Under/Over weight
☐ Yells A Lot
☐ Walking difficulty

Notes: _____

Medical History

Pediatrician Name/Phone: _____
Last physical date: _____
Glasses: _____
Medications: _____

Health Issues:

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Bowel problems
- ☐ Ear infection
- ☐ Ear/eye issues
- ☐ Head injury
- ☐ Heart problems
- ☐ High fever
- ☐ Kidney/urinary
- ☐ Lead poisoning
- ☐ Measles/M/R/Chicken Pox
- ☐ Meningitis
- ☐ Neurological problems
- ☐ Other poisoning
- ☐ Pneumonia
- ☐ Rashes
- ☐ Seizures

Hospitalizations: _____ Dates: _____ How long: _____
Notes: _____

Family Health History

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

Notes: _____

Educational History

School	Grade	Time attended	Services received

Adjustment issues (when, interventions): _____

Grade repeated: _____ When: _____

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

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

Notes: _____

Home Behavior ***Temperament***

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

Notes: _____

How do you reward/discipline your child? _____
Who usually disciplines? _____
Do caretakers agree on discipline? _____
Does your child complete chores? _____

Adaptive Skills

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

Notes: _____

Peer Relationships

☐ Difficulty relating to other children ☐ Prefers to play alone

Prefers friends that are: ☐ Older ☐ Younger ☐ Both

Role in-group games: _____
Notes: _____

Strengths

Hobbies and Interests: _____

Describe your child: _____

What are his/her positive attributes?

_____

Emergency Contact Name and Phone: _____

Notes: _____

Date: _____

Informant: _____ Social Worker/Psychologist: _____

Informant: _____ Interpreter: _____