MADISON COUNTY JUVENILE COURT

SOCIAL HISTORY 1

TO PARENT: IN ORDER TO UNDERSTAND YOUR CHILD’S NEEDS AND PROVIDE THE APPROPRIATE SERVICES FOR YOUR CHILD WE ASK YOU TO COMPLETE THIS FORM IN ITS ENTIRETY. IF YOU HAVE ANY QUESTIONS FEEL FREE TO ASK ONE OF OUR STAFF MEMBERS.

AFTER COMPLETING THIS FORM SAVE IT TO YOUR COMPUTER AND E-MAIL IT TO paul.fontaine@alacourt.gov

TODAYS DATE: Click here to enter a date.

§CHILD’S INFORMATION §

CHILD’S FULL NAME:\_\_\_Click here to enter text.

  LAST FIRST MIDDLE

OTHER NAMES THE CHILD USES (ALIAS, NICKNAME):\_\_ Click here to enter text.

D.O.B.\_\_\_\_\_Click here to enter a date.

PLACE OF BIRTH\_\_\_Click here to enter text.

HOME TELEPHONE:\_\_\_\_Click here to enter text.

SOCIAL SECURITY #\_\_\_\_\_Click here to enter text.

DRIVER’S LICENSE#\_\_\_\_\_\_Click here to enter text.

ADDRESS:\_\_\_\_\_Click here to enter text.

CITY:\_\_\_\_\_\_\_Click here to enter text.

STATE:\_\_\_\_\_Click here to enter text.

ZIP:\_\_\_\_\_Click here to enter text.

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)\_\_\_\_Click here to enter text.

CITY:\_\_\_\_\_\_ Click here to enter text.:

STATE:\_\_\_\_\_ Click here to enter text.

ZIP:\_\_\_\_\_\_\_\_\_ Click here to enter text.

RACE:\_\_\_\_ Click here to enter text.

SEX:\_\_\_\_\_ Click here to enter text.

HT:\_\_\_\_\_\_ Click here to enter text.

WT:\_\_\_\_\_ Click here to enter text.

EYES:\_\_\_ Click here to enter text.

HAIR:\_\_\_ Click here to enter text.

LIST SCARS & TATTOOS:\_\_\_\_\_\_ Click here to enter text.

* DOES CHILD HAVE HEALTH INSURANCE: [ ]  YES [ ]  NO

INSURANCE PROVIDER:\_\_\_\_\_\_ Click here to enter text.

POLICY # \_\_\_\_\_\_ Click here to enter text.

INSURANCE PROVIDER (2ND):\_\_\_\_\_\_ Click here to enter text.

POLICY # \_\_\_\_\_\_ Click here to enter text.

§ SOCIAL SERVICES §

* HAVE YOU EVER HAD CONTACT WITH A SOCIAL WORKER OR DEPARTMENT OF HUMAN RESOURCES (DHR) WORKER? [ ]  YES [ ]  NO

NAME OF THE SOCIAL OR DHR WORKER:\_\_\_\_\_\_ Click here to enter text.

COUNTY:\_\_\_\_\_Click here to enter text.\_

STATE:\_\_\_\_\_Click here to enter text.

* PLEASE CHECK ANY BENEFITS FAMILY RECEIVES:

[ ]  AFDC

[ ]  FOOD STAMPS

[ ]  CHILD SUPPORT

[ ]  SSI

[ ]  DISABILITY

## **§ FAMILY §**

* ARE THE NATURAL PARENTS:

[ ]  MARRIED

[ ]  SINGLE

[ ]  DIVORCED

[ ]  SEPARATED

[ ]  NEVER MARRIED

[ ]  UNKNOWN

WHO IS THE LEGAL GUARDIAN:

[ ]  NATURAL PARENTS

[ ]  MOTHER/STEPFATHER

[ ]  FATHER/STEPMOTHER

[ ]  ADOPTIVE PARENTS

[ ]  FOSTER PARENTS

[ ] OTHER\_Click here to enter text.

IF A PARENT(S) IS DECEASED PLEASE LIST NAME & DATE OF DEATH

 Click here to enter text.

legal guardian

legal guardian (1)\_\_Click here to enter text.

 LAST FIRST MIDDLE

DATE OF BIRTH:\_\_\_\_\_ Click here to enter text.

RELATIONSHIP:\_\_\_\_\_\_ Click here to enter text.

ADDRESS: \_\_\_ Click here to enter text.

ZIP CODE:\_\_\_ Click here to enter text.

HOME TELEPHONE:\_\_ Click here to enter text.

WORK TELEPHONE:\_\_\_\_\_ Click here to enter text.

CELL TELEPHONE:\_\_\_ Click here to enter text.

E-MAIL ADDRESS:\_\_\_ Click here to enter text.

EMPLOYER:\_\_\_ Click here to enter text.

OCCUPATION:\_\_\_ Click here to enter text.

legal guardian (2)\_\_Click here to enter text.

 LAST FIRST MIDDLE

DATE OF BIRTH:\_\_\_\_\_ Click here to enter text.

RELATIONSHIP:\_\_\_\_\_\_ Click here to enter text.

ADDRESS: \_\_\_ Click here to enter text.

ZIP CODE:\_\_\_ Click here to enter text.

HOME TELEPHONE:\_\_ Click here to enter text.

WORK TELEPHONE:\_\_\_\_\_ Click here to enter text.

CELL TELEPHONE:\_\_\_ Click here to enter text.

E-MAIL ADDRESS:\_\_\_ Click here to enter text.

EMPLOYER:\_\_\_ Click here to enter text.

OCCUPATION:\_\_\_ Click here to enter text.

FATHER’S NAME:\_\_\_\_\_ Click here to enter text.

 LAST FIRST MIDDLE

DATE OF BIRTH:\_\_\_\_\_\_ Click here to enter text.

ADDRESS: \_\_\_ Click here to enter text.

ZIP CODE:\_\_\_ Click here to enter text.

HOME TELEPHONE:\_\_\_\_ Click here to enter text.

WORK TELEPHONE:\_\_\_\_\_ Click here to enter text.

CELL TELEPHONE:\_\_\_\_\_\_ Click here to enter text.

OTHER TELEPHONE NUMBER:\_\_\_\_ Click here to enter text.

E-MAIL ADDRESS:\_\_\_\_\_ Click here to enter text.

EMPLOYER:\_\_\_\_\_\_ Click here to enter text.

OCCUPATION:\_\_\_\_ Click here to enter text.

MOTHER’S NAME:\_\_\_\_ Click here to enter text.

 LAST FIRST MIDDLE

DATE OF BIRTH:\_\_\_\_\_ Click here to enter text.

ADDRESS:\_\_\_ Click here to enter text.

ZIP CODE:\_\_\_\_ Click here to enter text.

HOME TELEPHONE:\_\_\_\_ Click here to enter text.

WORK TELEPHONE:\_\_\_\_ Click here to enter text.

CELL:\_\_\_\_\_ Click here to enter text.

E-MAIL ADDRESS:\_\_\_\_\_ Click here to enter text.\_

EMPLOYER:\_\_\_\_\_ Click here to enter text.

OCCUPATION:\_\_\_\_\_\_ Click here to enter text.

LIST EVERYONE THAT LIVES IN THE HOME TO INCLUDE THE PARENTS/GUARDIAN:

NAME:\_\_ Click here to enter text.

RELATIONSHIP:\_Click here to enter text.

AGE:\_\_Click here to enter text.

NAME:\_Click here to enter text.

RELATIONSHIP:\_\_

AGE:\_Click here to enter text.

NAME:\_Click here to enter text.

RELATIONSHIP:\_\_ Click here to enter text.

AGE:\_Click here to enter text.

NAME:\_Click here to enter text.

RELATIONSHIP: \_Click here to enter text.

AGE:\_Click here to enter text.

NAME:\_Click here to enter text.\_

RELATIONSHIP:\_ Click here to enter text.

AGE:\_Click here to enter text.

NAME:\_\_ Click here to enter text.

RELATIONSHIP:\_Click here to enter text.

AGE:\_\_Click here to enter text.

NAME:\_Click here to enter text.

RELATIONSHIP:\_\_

AGE:\_Click here to enter text.

NAME:\_Click here to enter text.

RELATIONSHIP:\_\_ Click here to enter text.

AGE:\_Click here to enter text.

* DO YOU AND YOUR CHILD HAVE TRANSPORTATION?

 [ ]  YES [ ]  NO

* IS MEANS OF TRANSPORTATION RELIABLE? [ ]  YES [ ]  NO
* HAVE YOU, THE PARENT, EVER BEEN A VICTIM OF DOMESTIC VIOLENCE? [ ]  YES [ ]  NO
* IF YES, PLEASE EXPLAIN BY PROVIDING DATES; IF THERE WAS DHR INVOLVEMENT; IF OFFENDER WAS A FAMILY MEMBER; NAME OF OFFENDER:\_\_\_\_\_ Click here to enter text.
* WHAT IS THE MONTHLY INCOME FOR YOUR HOUSEHOLD:\_

 Click here to enter text.

§ education §

* WHAT SCHOOL IS YOUR CHILD CURRENTLY ENROLLED:

Click here to enter text.

* WHAT GRADE IS CHILD IN:\_\_\_\_\_ Click here to enter text.
* IF NOT CURRENTLY ENROLLED WHAT WAS LAST SCHOOL ATTENDED:

Click here to enter text.

* LAST GRADE COMPLETED:\_\_\_\_\_ Click here to enter text.\_
* HAS THE CHILD: [ ]  OFFICIALLY DROPPED OUT [ ]  QUIT SCHOOL
* IS THEIR ATTENDANCE:

[ ]  EXCELLENT

[ ]  GOOD

[ ]  FAIR

[ ]  POOR

* OVERALL GRADES:

[ ]  A’s

[ ]  B’s

[ ]  C’s

[ ]  D’s

[ ]  F’s

* HAS YOUR CHILD EVER RECEIVED:

[ ]  IN SCHOOL SUSPENSION

[ ]  OUT OF SCHOOL SUSPENSION

[ ]  EXPULSION

EXPLAIN WHAT HAPPENED, ENTER DATES:\_\_\_ Click here to enter text.

* DOES YOUR CHILD OR HAS YOUR CHILD EVER ATTENDED SPECIAL EDUCATION OR LEARNING STRATEGIES CLASSES?

[ ]  YES

[ ]  NO

* IF YES, PLEASE EXPLAIN:\_\_\_\_ Click here to enter text.

§ behavior §

* DOES YOUR CHILD SHOW ANY OF THE FOLLOWING BEHAVIORS:

 (CHECK ALL THAT APPLY)

[ ]  RUNAWAY

[ ]  TRUANCY

[ ]  STEALING

[ ]  ASSAULTIVE

[ ]  INSUBORDINATE

[ ]  HYPERACTIVE

[ ]  DISRUPTIVE

[ ]  DIFFICULTY EATING

[ ]  SEXUALLY INAPPROPRIATE

[ ]  MOODSWINGS

[ ]  DIFFICULTY SLEEPING

* ARE YOU AFRAID OF YOUR CHILD? [ ]  YES [ ]  NO

IF YES, PLEASE EXPLAIN:\_\_\_ Click here to enter text.

* DOES CHILD HAVE A JOB? [ ]  YES [ ]  NO
* PLACE OF EMPLOYMENT:\_\_\_ Click here to enter text.
* PHONE #\_\_\_ Click here to enter text.

## § **MEDICAL** §

* DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?

[ ]  DIABETIES TYPE:\_\_\_\_ Click here to enter text.

[ ]  ASTHMA

[ ]  SEIZURES

[ ]  HEAD INJURY

[ ]  NONE

* DOES YOUR CHILD HAVE ANY OTHER MEDICAL CONDITIONS, DISORDERS OR SEXUALLY TRANSMITTED DISEASES?

 [ ]  YES [ ]  NO

* PLEASE LIST:\_\_\_ Click here to enter text.
* DOES YOUR CHILD HAVE ANY PHYSICAL LIMITATIONS OR DISABILITY THAT MIGHT REQUIRE SPECIAL ASSISTANCE OR ACCOMODATIONS?

 [ ]  YES [ ]  NO

IF YES, PLEASE EXPLAIN\_Click here to enter text.

* PLEASE LIST ALL ALLERGIES (FOODS, MEDICATIONS, INSECT BITES, POLLEN, MOLD):\_\_\_ Click here to enter text.

§mental health §

* HAS YOUR CHILD EVER BEEN DIAGNOSED WITH A MENTAL DISORDER OR MENTAL ILLNESS? [ ]  YES [ ]  NO
* PLEASE LIST:\_\_\_\_ Click here to enter text.
* NAME OF DOCTOR WHO MADE DIAGNOSIS:\_\_\_ Click here to enter text.
* WHEN WAS DIAGNOSIS MADE?\_\_\_ Click here to enter text.

* HAS CHILD EVER REFUSED TO SEE A MENTAL HEALTH WORKER? [ ]  YES [ ]  NO

 IF YES, PLEASE EXPLAIN:\_\_\_\_ Click here to enter text.

* IS/DOES YOUR CHILD ASSOCIATE WITH DELINQUENT FRIENDS?

 [ ]  YES [ ]  NO

* IS YOUR CHILD SEXUALLY ACTIVE? [ ]  YES [ ]  NO
* WHAT IS YOUR CHILD’S SEXUAL PREFERENCE?\_\_ Click here to enter text.
* IS YOUR CHILD A PARENT? [ ]  YES [ ]  NO

IF YES, HOW MANY CHILDREN:\_\_ Click here to enter text.

AGES:\_\_ Click here to enter text.

PLEASE LIST ALL MEDICATIONS YOUR CHILD IS TAKING. BELOW ARE SOME OF THE COMMON DRUGS THAT MAY ASSIST YOU IN REMEMBERING YOUR CHILD’S MEDICATION. IF NONE PLEASE CHECK: [ ]  NO MEDICINE

 ABILIFY ADDERALL ALBUTEROL CELEXA CONCERTA

CYMBALTA DEPAKOTE EFFEXOR GEODON KLONOPIN

LITHIUM NEURONTIN PAXIL PROZAC REMERON RISPERDAL

RITALIN SEROQUEL TEGRETOL TRAZADONE WELLBUTRIN

XANAX ZOLOFT ZYPREXA BIRTH CONTROL

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | MEDICATION | DOSAGE | NAME THE DOCTOR WHO PRESCRIBED THE MEDICINE | DOCTOR’S TELEPHONE NUMBER | WHAT IS THE MEDICATION USED FOR? |
|  | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. |  | Click here to enter text. | Click here to enter text. | Click here to enter text. |

* IS YOUR CHILD NOT TAKING HIS/HER PRESCRIBED MEDICATION(S) FOR ANY REASON? [ ]  YES [ ]  NO

 IF YES, PLEASE EXPLAIN:\_\_\_\_ Click here to enter text.

§family history§

* HAS ANYONE IN YOUR FAMILY EVER BEEN DIAGNOSED WITH A MENTAL DISORDER OR MENTAL ILLNESS? [ ]  YES [ ]  NO

 IF YES, PLEASE EXPLAIN:\_\_ Click here to enter text.

* HAS ANYONE IN YOUR FAMILY EVER COMMITTED OR ATTEMPTED SUICIDE? [ ]  YES [ ]  NO

 IF YES, PLEASE EXPLAIN:\_\_\_ Click here to enter text.

* HAS YOUR CHILD EVER BEEN HOSPITALIZED OR PLACED IN A TREATMENT CENTER? (PLEASE CHECK ALL THAT APPLY)

[ ]  PSYCHOLOGICAL

[ ]  DRUG/ALCOHOL

[ ]  MEDICAL

[ ]  NONE

LIST FACILITY, DATE AND REASON FOR ADMISSION AND HEALTH CARE PROFESSIONAL RESPONSIBLE:\_ Click here to enter text.

* HAS YOUR CHILD EVER BEEN ABUSED (PHYSICALLY, SEXUALLY, MENTALLY) OR NEGLECTED? [ ]  YES [ ]  NO

OFFENDERS NAME:\_Click here to enter text.

RELATIONSHIP\_Click here to enter text.

DATE OF OFFENSE\_Click here to enter a date.

PLEASE EXPLAIN ALLEGATION:\_Click here to enter text.

HAS CHARGES BEEN FILED AGAINST THE OFFENDER? [ ]  YES [ ]  NO

§ ALCOHOL/DRUGS§

* DO YOU SUSPECT THAT YOUR CHILD IS USING DRUGS?

 [ ]  YES [ ]  NO

* DO YOU SUSPECT THAT YOUR CHILD IS USING alcohol?

 [ ]  YES [ ]  NO

IF YES, LIST SUBSTANCES SUSPECTED AND IF USING NEEDLES:

\_\_ Click here to enter text.

* HAS YOUR CHILD EVER BEEN DRUG TESTED? [ ]  YES [ ]  NO

WERE TEST RESULTS: [ ]  POSITIVE [ ] NEGATIVE

IS THERE A HISTORY OF DRUG OR ALCOHOL ABUSE IN YOUR FAMILY?

 [ ]  YES [ ]  NO

 IF YES, PLEASE EXPLAIN:\_ Click here to enter text.

§ LEGAL §

* HAS YOUR CHILD EVER BEEN CHARGED WITH A JUVENILE OFFENSE? [ ]  YES [ ]  NO
* HAS YOUR CHILD EVER BEEN PLACED ON PROBATION?

 [ ]  YES [ ]  NO

* LIST CHARGE/S:\_\_\_ Click here to enter text.

PROBATION OFFICER:\_\_\_ Click here to enter text.

COUNTY:\_\_\_ Click here to enter text.

STATE:\_\_\_\_ Click here to enter text.

* HAS YOUR CHILD EVER BEEN CHARGED WITH AN ADULT OFFENSE?

 [ ]  YES [ ]  NO

* LIST CHARGE:\_ Click here to enter text.

* DO YOU HAVE ANY WEAPONS SUCH AS GUNS OR OTHER DANGEROUS INSTRUMENTS IN YOUR HOME? [ ]  YES [ ]  NO

 IF YES, PLEASE EXPLAIN:\_ Click here to enter text.

* IF YOU ANSWERED YES TO QUESTION #3, ARE THE WEAPONS LOCKED OR KEPT IN A SAFE PLACE? [ ]  YES [ ]  NO
* HOW WOULD YOU RATE YOU CHILD’S OVERALL BEHAVIOR?

[ ]  EXCELLENT

[ ]  GOOD

[ ]  FAIR

[ ]  POOR

* LIST YOUR CHILD’S POSITIVE QUALITIES AND STRENGTHS:

\_ Click here to enter text.

* DO YOU HAVE A GOOD RELATIONSHIP WITH YOUR CHILD? [ ]  YES [ ]  NO

PLEASE EXPLAIN:\_\_\_ Click here to enter text.

* HAS ANY PARENT, GUARDIAN OR SIBLING EVER BEEN ON PROBATION OR INCARCERATED? [ ]  YES [ ]  NO

LIST NAME, OFFENSE AND DATE:\_\_ Click here to enter text.

* IS THERE ANYTHING ELSE THAT WOULD BE HELPFUL FOR US TO KNOW ABOUT YOUR CHILD OR YOUR FAMILY?

 [ ]  YES [ ]  NO

IF YES, PLEASE PROVIDE AN EXPLANATION

 Click here to enter text.

Click here to enter text. Click here to enter a date.

PARENT/GUARDIAN SIGNATURE / PLEASE TYPE NAME DATE

 Click here to enter text. Click here to enter a date.

 STAFF SIGNATURE / TYPE NAME DATE

NOTES (PARENT OR PROBATION OFFICER):

 Click here to enter text.

SAVE THIS TO YOUR COMPUTER AND E-MAIL IT TO: paul.fontaine@alacourt.gov