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](mailto: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