



**SOCIAL HISTORY**

**Family Information**

Mother's Name: \_\_\_\_\_ Mother's Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Father's Occupation: \_\_\_\_\_

Siblings:  Yes  No Sibling Names and ages: \_\_\_\_\_

Guardian Name and Relationship (if applicable): \_\_\_\_\_

If parents live separately, where is the child's primary residence? \_\_\_\_\_

Who lives at home? \_\_\_\_\_

Are there pets in the home?  Yes  No If yes, specify \_\_\_\_\_

Does anyone in the home smoke?  Yes  No

**Child Care and Education**

Does this child attend child care?  Yes  No

If yes, what is the name of the child care center? \_\_\_\_\_ If yes, how many hours per week? \_\_\_\_\_

Does this child attend school?  Yes  No

If yes, what is the name of the school? \_\_\_\_\_ If yes, what grade? \_\_\_\_\_

Do you have concerns about your child's adjustment or performance in school?  Yes  No

If yes, please explain: \_\_\_\_\_

**Learning Needs**

Is your primary language English?  Yes  No If no, indicate primary language \_\_\_\_\_

How would you like health information about your child/youth presented?

1:1 Conversation with health care provider  Reading Materials  Classroom  Other

Who makes up your household? (check all that apply):

Single Parent  Two Parent Household  Siblings  Other (family)  Other's (not family)

**Interests/Hobbies/Recreational Activities**

**Tobacco Exposure** (check all that apply)

Patient is a smoker  Smokers in the home  Smoke outside only

**Activity** (check all that apply)

Exercise/Sports (Hours per day) \_\_\_\_\_  TV/Computer games (Hours per day) \_\_\_\_\_

Internet (Hours per day) \_\_\_\_\_  Text Messaging (Hours per day) \_\_\_\_\_

**Sleep** (Check all that apply)

Takes Naps  Sleeps with parents  Sleeps through the night  Min. 8 hours nightly  Sleep problems

**Safety** (Check all that apply)

Bike helmet  Rear facing car seat  Front facing car seat  Booster  Seat belt  Carbon Monoxide Detector

Smoke Detector  Radon Detector  Firearms in the home  Pool/Spa  Pets/Animals-type & number \_\_\_\_\_

**CONCERNS**

Please list any concerns regarding the health of this child in the space provided.

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**Name and Relationship of Person Completing Form (print):**

Signature \_\_\_\_\_

Date: \_\_\_\_\_

We would like to thank you for taking the time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit.