Different Like Me, Inc.

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1200 NW 17th Avenue, , Suite 12, Delray Beach, Fl 33486
Phone (561) 270-2280

Social History

Client's Name _____ male or female
First Middle Last (circle one)

Date of Birth _____ Current Age_____

Home
Address_____

_____

Telephone_____
Home Parent's work Cellular

Who has legal custody of the client?_____

Name of School:_____

Type of Class: _____Grade_____

Who lives with or interact with child frequently:
Name Age Birthplace Level of Education/Employment

1. _____

2._____

3._____

4. _____

5._____

6._____

7._____

Has child been diagnosed with any medical or mental health condition? _____ If yes please describe _____

_____

Name: _____ DOB: _____

Main reason for seeking treatment is: _____

Describe how these difficulties first started and how they have progressed over time:

Were there any explanations or circumstances for the above difficulties that you know of:

Has anything made patient's problem worse or better over time? _____

How is the family reacting to these difficulties? _____

What are the main household stressors (money, illness, employment)? _____

What is the family's views of the child's problem? _____

Who will be involved in the child's treatment _____

Describe any challenges in School _____

Has your child been diagnosed with any learning or physical disabilities? _____

Name: _____ DOB:_____

Describe any family history that may be helpful. (Autism, ADD, OCD, Anxiety, Learning Disabilities, etc.) _____
_____
_____

Please check all that apply or are of concern:

_____Anxiety
_____Anger
_____Preoccupation with subject or objects* explain_____
_____Sadness
_____Depression
_____Obsessed with thoughts
_____Compulsive behaviors
_____Sensory challenges
- _____Food
- _____Clothing
- _____Textures
- _____Sounds
- _____Light
- _____Other_____ _____

_____Attention Difficulties
_____Frustration
_____Worry
_____Relationship Challenges
_____Bullying
_____Social Skills
_____Odd Habits/Behaviors
_____Other _____
_____

What is your expectation of the outcome of treatment? _____
_____
_____

Birth history:
Were there any pregnancy complications?
_____
Delivery type _____

Name: _____ DOB:_____

Length of term _____
Hospital of Birth _____
Birth weight _____
Complications _____
Treatments /surgeries _____
Feeding or sleeping difficulties_____

Milestones: (please indicate ages if available or that skills were mastered within normal limits)
Lifted head_____
Rolled over_____
Crawled_____
Sitting independently_____
Standing independently _____
Walking independently_____
First words _____
2 words together_____
Sentences_____
Toilet trained_____
Eating habits_____
Sleeping habits _____
Allergies _____
Ear infections _____
Medications_____
Physician_____
General description of child_____
_____

Social description; (please describe and/or indicate difficulties/delays)
Personality_____
affection to others _____
temperament_____
tantrums, impulse control_____
attention span_____
separation_____
Social Skills_____
Habits, odd behaviors _____

Cognitive description:
Level of Understanding_____
Follows commands_____
Numbers, letters, shapes_____

Type of play preferred_____
Able to communicate wants and needs_____
Fine motor development_____
Gross motor development_____

Any difficulties with ADL's:
Feeding_____
Hygiene _____
Dressing_____