



Silver Psychiatric Services

Randie Schacter, DO

212 W. Matthews St.
Matthews NC, 28105
Tel: 704-847-0424 Fax: 704-847-0454
www.silverpsychiatric.com

SOCIAL AND DEVELOPMENTAL HISTORY

Completed by: Mother Father Legal Guardian _____

Other (explain relationship to patient) _____

Referring Person: _____ Phone: _____

Identification:

Patient Name: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____

Date of Birth: _____ Age: _____ Religion: _____ Race: _____

School Information:

School: _____ Grade: _____

Regular Ed: _____ Special Ed (type) _____

Special Services (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Resource Room (%time) _____ | <input type="checkbox"/> Speech/Language |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Adaptive Physical Education | <input type="checkbox"/> Advanced placement |
| <input type="checkbox"/> Other _____ | |

Name

Phone

Guidance Counselor: _____

School Psychologist: _____

Teacher: _____

Other: _____

Primary Care Doctor: _____

Mental Health Caregiver(s): _____

(If applicable) _____

Social Service Agency (if applicable)

Name: _____

Service: _____

Contact person: _____ Phone: _____

Referring Person(s): _____



Other Information:

Mother:

Name: _____ Age: _____ DOB: _____

Address (if different): _____

Phone – Home: _____ Work: _____ Cell: _____

Place of Birth: _____ Social Security # _____

Education: _____

Occupation: _____ Place of Business: _____

How long at present job: _____

Insurance policy name: _____ Ins. Policy No.: _____

Religion: _____ Race: _____

Please Check: Biological Parent Adoptive Parent Foster Parent Step-parent

Emergency contact: _____ Phone: _____

Father:

Name: _____ Age: _____ DOB: _____

Address (if different): _____

Phone – Home: _____ Work: _____ Cell: _____

Place of Birth: _____ Social Security # _____

Education: _____

Occupation: _____ Place of Business: _____

How long at present job: _____

Insurance policy name: _____ Ins. Policy No.: _____

Religion: _____ Race: _____

Please Check: Biological Parent Adoptive Parent Foster Parent Step-parent

Emergency contact: _____ Phone: _____

Parents/Guardian:

Are parents married? Yes No Date of Marriage: _____

Are parents living together? Yes No

If no, are parents: Separated Date of Separation: _____

Divorced Date of Divorce: _____

Deceased Date: _____

Who is the legal custodian?

Name: _____

Relationship to parent: _____

Address: _____

Phone: _____



Reason for seeking treatment for your child:

Multiple horizontal lines for writing the reason for seeking treatment.

Major changes or stressors:

Have there been or are there currently any major changes or stresses in the family where your child was brought? Yes No

If yes please mark all that apply:

In the past (More than 1 yr ago) Current (1 yr ago or less):

Two columns of horizontal lines for marking changes or stressors in the past and current.

FAMILY

- 1. Drinking/drug problems
2. Arguments between parents
3. Physical confrontation between parents
4. Separation or divorce of parents
5. Remarriage of parent(s)
6. Separation from sibling(s)
7. Separation from other family members
8. Separation from significant non-family members
9. Medical illness in family
10. Medical hospitalization of a parent
11. Psychiatric hospitalization in family
12. Death in family
13. Incestuous behavior in family
14. Financial problems in family
15. Legal problems in family
16. Frequent moves
17. Job changes
18. Frequent physical punishments of child
19. Other family problems
20. Other traumatic situations

In the past (More than 1 yr ago) Current (1 yr ago or less):

Two columns of horizontal lines for marking changes or stressors in the past and current.

CHILD

- 1. Drinking/drug use
2. Arguments with parents
3. Self-harm (cutting, burning)
4. Sexual behaviours
5. Restricting food intake
6. Excessive food intake
7. Truancy from school
8. Conflicts with teacher(s)
9. Arguments/fights with peers
10. Physical confrontation with parents



Silver Psychiatric Services

Social History:

List **all** of the family and significant others in the household:

| Name | Relationship | Age | Occupation | Quality of Relationship (good, poor, conflicted) |
|----------|--------------|-------|------------|---|
| 1. _____ | _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ | _____ |
| 5. _____ | _____ | _____ | _____ | _____ |

List the family and significant others **not** in the home

| Name | Relationship | Age | Geographic Location | Phone Number |
|----------|--------------|-------|---------------------|--------------|
| 1. _____ | _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ | _____ |
| 5. _____ | _____ | _____ | _____ | _____ |

Developmental History:

Duration of pregnancy (in weeks): _____

Labor: Duration: _____ Any problems, specify: _____

Delivery: Vaginal C-section Any problems, specify: _____

New born period: Normal Any problems, specify (oxygen, incubator, infection, jaundice requiring treatment, breathing difficulty, etc.): _____

First year – Temperament

- Easy baby
- Slow to warm up (give example) _____
- Difficult baby (give examples) _____
- Eating habits (normal or abnormal) _____
- Sleeping habits (normal or abnormal) _____
- Colic (if yes, for how long) _____
- Sat up at what age _____
- Walked at what age _____

Other Milestones:

First words at age _____ Three word sentence at age _____

Toilet training at age – Bladder _____ Bowel _____

Any current problem with wetting or soiling (specify)? _____

Adolescent Development:

Age at first menses _____ Last menstrual period _____

Sexually active Yes No Unknown

Peer relationships: Satisfactory Unsatisfactory

Explain: _____

Substance Use: (circle)

| No | Yes | | Uses per week | Date of last Use |
|----|-----|-----------|---------------|------------------|
| No | Yes | Alcohol | _____ | _____ |
| No | Yes | Cocaine | _____ | _____ |
| No | Yes | Marijuana | _____ | _____ |
| No | Yes | Opioids | _____ | _____ |
| No | Yes | Sedative | _____ | _____ |
| No | Yes | Ecstasy | _____ | _____ |
| No | Yes | Nicotine | _____ | _____ |
| No | Yes | Caffeine | _____ | _____ |
| No | Yes | Others | _____ | _____ |



School History:

- Attended Preschool Yes No
- Adjustment Satisfactory Unsatisfactory, specify _____
- Academic Progress Satisfactory Unsatisfactory, specify _____
- Social Progress Satisfactory Unsatisfactory, specify _____

| | Name of School | Any difficulties, specify |
|---------------------------|----------------|---------------------------|
| Kindergarten | _____ | _____ |
| Elementary Grades | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| Junior High/Middle school | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| High School | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

Legal problems: No Yes, specify _____

Family History of Emotional Disorders:

| | Relationship to patient | Treated/Untreated |
|-------------------------------------|-------------------------|-------------------|
| Schizophrenia | _____ | _____ |
| Depression | _____ | _____ |
| Manic Depression (Bipolar Disorder) | _____ | _____ |
| Anxiety | _____ | _____ |
| Panic Attacks | _____ | _____ |
| Obsessive –Compulsive Disorder | _____ | _____ |
| Substance Abuse/Dependence | _____ | _____ |
| Alcohol Abuse/Dependence | _____ | _____ |
| Anger Problems | _____ | _____ |
| Attention Deficit Hyperactivity | _____ | _____ |
| Behavior/Conduct Problems | _____ | _____ |
| Learning Problems | _____ | _____ |
| Tics | _____ | _____ |
| Mental Retardation | _____ | _____ |
| Suicide Attempts | _____ | _____ |
| Completed Suicide | _____ | _____ |
| Victim of Trauma (specify) | _____ | _____ |
| Eating Disorders | _____ | _____ |
| Gambling | _____ | _____ |

Previous Psychological/Psychiatric Treatment:

Have you ever received psychiatric or psychological treatment of any kind before? Yes No

If you checked yes to the above question please answer the following:

What type of care did you receive? Inpatient (hospital) Outpatient Both

Where were you in treatment?

When were you in treatment? _____

How long were you in treatment? _____

Who was your therapist or doctor? _____

Did your doctor prescribe Medicine at that time? Yes No Not applicable

If yes what was prescribed (include dosage, reaction, benefit if known)



Silver Psychiatric Services

(Continued previous medication trials, doses, reactions, benefit)

Current Medications: (please list all medications currently being taken including over the counter meds/vitamins)

| Name of Medication | How many MG or pills | Route (i.e. by mouth) | Date Began | Reason for Medication | Response |
|--------------------|----------------------|-----------------------|------------|-----------------------|----------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Medical History:

Date of most Recent Physical Exam: _____ Results: _____

Please provide the name and address of your physician or medical clinic: _____

Name: _____ Phone: _____

Address: _____

Are you now receiving treatment? _____

List below serious illnesses, accidents, or operations which you have had. Give the date of the illness or injury, and if you were hospitalized, give the name of the hospital, approximate length of stay, and the attending physician.

Allergies: _____

Activities of Daily Living (List any problems or need for assistance with the following):

| | Independent | Partial Assistance | Total Assistance | Comments |
|---------------------------|-------------|--------------------|------------------|----------|
| Eating | | | | |
| Sleeping | | | | |
| Dressing | | | | |
| Ambulation | | | | |
| Hygiene-Bathing/Showering | | | | |
| Elimination-Toileting | | | | |

Reviewed by: _____ **Date:** _____