Chapel Hill Children & Adolescents' Clinic
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Chapel Hill, NC 27516
(919) 967-0771 Fax (919) 967-9207

SOCIAL HISTORY

DATE: _____ FOR OFFICE USE:

PATIENT NAME: _____ PATIENT NUMBER

DATE OF BIRTH: _____

SIBLING(S) AND DATES OF BIRTH: _____

_____

_____

Please list those who live in the same home as the child(ren):

Name	Relationship	Date of Birth

If the child's parents do not live together, what is the custody status? _____

_____

Occupations of parents or caregivers: _____

_____

Highest level of education of parents or caregivers: _____

_____

Does anyone in the home use tobacco? Yes ○ No ○

Are there guns in the home? Yes ○ No ○ If yes, are they locked up? Yes ○ No ○

In the last year, our family ran out of food or worried that we would run out of food before we had money to buy more. Yes ○ No ○

In the past year, has either parent of caregiver had a drinking problem? Yes ○ No ○

Has either parent or caretaker ever had a drug problem? Yes ○ No ○

When you were a child, how were you disciplined? _____

_____

How strong are your family's religious beliefs or practices? (circle one)
Very strong ○ Moderately strong ○ Not strong ○ Not applicable ○
What is your religion, if your family has an affiliation? _____

How often do you read bedtime stories to your child? (circle one)
Frequently ○ Often ○ Occasionally ○ Rarely ○ Never ○ Not applicable ○

How often does your family eat meals together? (circle one)
Frequently ○ Often ○ Occasionally ○ Rarely ○ Never ○

What does your family do together for fun? _____

_____