



BUTTE COUNTY CHILDREN'S SERVICES
FAMILY HISTORY INVENTORY

The information requested in this questionnaire is needed to prepare an accurate report to the Juvenile Court at the Dispositional Hearing. Please provide the information asked for and return it to your social worker by _____

If you wish, your social worker will gladly assist you in completing this form. Included in this questionnaire is a Statement Form, which will be filed with the Dispositional Report. It is an opportunity for you to express, in your own words, any information you would like the judge to know about your situation.

If you have any questions, please contact your social worker at _____

Some of the questions may not apply to you, if so, leave them blank.

Your Name (include middle name): _____

Birth Name (or AKA): _____

Social Security Number: _____

Driver's License/State ID Number: _____ State: _____

Date of Birth: _____ Place of Birth: _____

YOUR PARENTS:

Your Mother's Name: _____ Birth Name: _____

Is your mother living? Yes No . If not, date of death: _____

What was the cause of death? _____

If living, Mother's Current Address: _____

_____ Phone Number: _____

Your Father's Name: _____

Is your father living? Yes No . If not, date of death: _____

What was the cause of death? _____

If living, Father's Current Address: _____

_____ Phone Number: _____

Were your parents married? Yes No

YOUR BROTHERS:

<u>Name:</u>	<u>Date of Birth:</u>	<u>Same parent as you?</u>
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

YOUR SISTERS:

<u>Name:</u>	<u>Date of Birth:</u>	<u>Same parent as you?</u>
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

YOUR CHILDREN:

<u>Name:</u>	<u>DOB:</u>	<u>Other Parent</u>	<u>Married to Parent?</u>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

Please provide information about parent(s) of your children not living with you:

Name:

DOB:

Address & Phone Number:

YOUR RELATIONSHIPS:

Names: Dates Dates
Begun/Separated Married-Divorced Married-Divorced

_____	_____/_____	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	_____/_____
_____	_____/_____	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	_____/_____
_____	_____/_____	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	_____/_____
_____	_____/_____	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	_____/_____

YOUR BACKGROUND:

In what cities, states and countries have you lived?

Place:

Dates (from/to):

_____	_____/_____
_____	_____/_____
_____	_____/_____
_____	_____/_____
_____	_____/_____

With whom did you live while growing up? _____

How would you describe your childhood? _____

Did you see violence in the family? If so, Please explain: _____

How were you disciplined? _____

Did anyone sexually abuse you? If so, please explain: _____

Were drugs or alcohol a problem in your home? If so, please explain: _____

Have you ever used drugs or alcohol? Yes No

If yes, at what age did you first use alcohol? _____ drugs? _____

If yes, what kind of drugs have you used? _____

When did you last use drugs or alcohol? Indicate what was used: _____

Do you believe you have an alcohol or drug problem? Yes No

Are you in recovery? Yes No How long? _____

Have you ever received mental health services? Yes No

Have you ever taken medications for a mental illness? Yes No

If yes, what medications? _____

Are you taking medications now? Yes No

Who is your doctor? _____

Have you served in the Armed Forces? Branch? _____ Dates? _____

How old were you when you left home? _____ Under what circumstances? _____

EDUCATION:

What was the last grade you completed? _____

Where? _____

Did you graduate from High School? Yes No If yes, when? _____

Did you earn a GED? Yes No If yes, when? _____

Do you hold any degrees or certificates? _____

EMPLOYMENT HISTORY:

<u>Employed by:</u>	<u>Date (from/to):</u>	<u>Duties:</u>
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_____	_____/____/_____	_____
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_____	_____/____/_____	_____
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_____	_____/____/_____	_____
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_____	_____/____/_____	_____
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Are you currently employed? Yes No If yes, how long? _____

What is your current source of income? _____

CRIMINAL HISTORY:

Have you ever been convicted of a crime? Yes No

If so, what and when? _____
