1508

1926

REPORT OF SOCIAL SERVICE INVESTIGATION.

Outline for Psychiatric Social History.

NAME: CLAIM NUMBER:

RESIDENCE: RANK & ORGANIZATION:

MARITAL STATUS: RACE:

AGE: RELIGION:

PURPOSE OF INVESTIGATION:

Under this heading it should be indicated for what reason the case was referred to the social worker, whether for the purpose of securing a complete history or for some special investigation. The investigation may have several purposes and each of these should be stated. If the investigation is made for some special purpose it will generally be feasible to secure much of the social history at the same time.

I. FAMILY HISTORY.

A. IMMEDIATE FAMILY.

1. Father: Give full name, residence, nativity, education, occupation, habits, illnesses, general health, economic condition, age, etc. If dead give date, age, cause of death.

2. Mother: Give maiden name, residence, nativity, education, number of children, illnesses, general health, age, etc. If dead give date, age, cause of death.

3. Siblings: (Note "Siblings" is a word invented by Pearson to denote children of the same parents.) Are or were there siblings of patient? Give in order (noting male and female) and get ages if living, or ages at and causes of death, miscarriages, premature or still births, etc. Inquire regarding nervous and mental diseases, occupations and their general success in life.

4. Spouse: Give maiden name, residence, age, nativity, education, general health, etc. Give date and place of marriage, If dead give date, age, cause of death.

5. Children: How many children does patient have? Give them in order, noting sexes, ages, nervous and mental diseases, etc. Has patient's wife had abortions or miscarriages? Get details of the mental characteristics of the children, especially noting symptoms of retardation, precociousness, etc.

B. HEREDITY.

1. Paternal.

2. Maternal.

Make inquiries about the grandparents and antecedents so far as is feasible in each case. Inquire also regarding collateral descendents, i.e., uncles, aunts and cousins. If there are interesting trends of hereditary taints, give complete details in each case. Inquire into insanity, alcoholism, epilepsy, feeblemindedness, suicide, nervousness, criminal tendencies, depressions, drug addiction, venereal diseases, convulsions, goiter, fainting spells, periodic headaches, diabetes, tuberculosis, arthritis, paralysis.

C. IF SUFFICIENT DATA IS OBTAINABLE chart the family, using the standard symbols for this purpose. The chart should be merely an index to the text and should be full of details when the facts warrant.

II. PERSONAL HISTORY. (Previous to military service).

1. Birth and Early Development. Date and place of birth. Condition of mother during pregnancy (physical and mental health). Term of pregnancy, character of delivery, whether natural or instrumental, etc. Make inquiry about infancy and childhood, including eruption of teeth, walking and talking, etc.; abnormal development, malnutrition, infantile and childhood diseases, sequela, especially convulsions.

2. Education. Give chronological account of school progress. Age on entering, names of schools and kinds, length of time in each school, grades reached, grades skipped or repeated. Report any special difficulties or interests in studies; also relationship with schoolmates and teachers, including play activities. Note any abnormal manifestations during school years, such as truancy, or other forms of delinquency. Give an account of home and family relationships during childhood and adolescence.

3. Occupations. (Pre-war). Give chronological account of all work including full and part time jobs, how secured, names of employers, kinds of jobs, efficiency and wages, inclusive dates, reasons for changing.

4. Injuries, Diseases and Operations Prior to Enlistment. Make inquiries as to tuberculosis, pneumonia, influenza, venereal disease, etc. Investigate hospital records regarding injuries, serious sickness or mental upsets.

5. <u>Personality, Social Behavior and Habits</u>. Investigate alcoholic and drug habits. If intemperate, age at which drinking began, apparent cause of excesses, kinds of beverages consumed and approximate amounts; periodic or steady drinker; usual reaction to alcohol. If patient has taken drugs such as cocaine, morphine, etc., were they prescribed for him, or were they taken because of another's example or persuasion; in what quantities were they taken and over how long a period of time? Investigate sexual irregularities, criminal traits, tramp life, arrests and court records; also any anti-social conduct not resulting in arrests. What has been the general disposition of the patient,- his general attitude toward his environment? What were his ambitions and plans for the future?

III. MILITARY HISTORY.

As this topic is fully covered by information in the Veterans' Bureau files it is unnecessary to get more than the dates and organization unless it is desired to emphasize certain incidents which seem to be of significance in connection with the rest of the history.

What was the attitude of the patient toward entering military service?

IV. READJUSTMENT TO CIVIL LIFE.

1. Give an account of adaptability to home surroundings after return from service. If patient has married include an account of his marriage, giving any significant facts connected with it.

2. Investigate habits, morals, etc., since discharge. Particular attention should be given to changes in behavior, in mood, in manner of speech, in attitude toward others and toward work.

3. Give complete industrial histroy since military discharge, naming kinds of work undertaken, efficiency, wages, how long, when, where and by whom employed. Reasons for changing positions. Get both the claimant's and employer's views regarding the economic adjustment, earning power and employability.

V. HISTORY OF PRESENT DISABILITIES.

1. Give date and manner of onset, exciting causes, subsequent symptoms, intercurrent illnesses, complications, sequela, etc.

2. Give definite account of all medical treatment, stating when, where, how long and by whom treated. Get both the claimant's and physicians' views regarding the disabilities and treatment.

3. Give complete history of all hospitalizations, including names of institutions and dates of confinements.

VI. PRESENT CONDITION.

1. Home Environment. Give a description of the neighborhood and dwelling. Who constitute the members of the household and what relationship exists between them? What is the social status of the family? What is their financial condition? Is the condition of the home sanitary? (Give details regarding light, air, space, etc.).

2. Occupation. Is patient employed at the present time? Is his present work suitable from the standpoint of his physical and mental improvement?

3. Attitude toward Hospitalization. What is the attitude of the patient and his family toward further hospitalization? Are they willing to carry out medical recommendations?

4. Social Adjustment. To what extent is the patient socially and economically adjusted at the present time? Is he sociable or seclusive? How does he spend his spare time?

VII. SOURCES OF INFORMATION.

1. Informants. Give the names and addresses of informants, also their relationship to patient. (Arrange in order of importance of the information given.)

2. Impressions. Impressions to include informants' attitude toward patient, reliability, cooperation. If information is purposely withheld, give reasons. It is desired to indicate so far as possible the intelligence, mental make-up and veracity of informants.

3. Agencies' Records - Social Agencies. Indicate to what extent the patient or his family have been known to other social agencies.

NOTE: At the end of this report the psychiatric social worker may list the social problems involved and give a statement as to the contemplated social treatment.

____________________ Psychiatric Social Worker.

Compiled by ____________________

Address ____________________

Date ____________________