



**DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES  
DIVISION OF PUBLIC WELFARE  
BUREAU OF SOCIAL SERVICES ADMINISTRATION  
194 Hernan Cortez Avenue, Suite 309  
Hagatna, Guam 96910-5052  
Telephone No: (671) 475-2653/2672**



**SOCIAL STUDY QUESTIONNAIRE**

**Note: Please type or print legibly in black or blue ink.**

<b>A. <u>Personal Information:</u></b>		
Legal Name: (Last):	(First):	(Middle):
Date of Birth:	Age:	
Place of Birth – City & State:		
Citizenship:	Ethnicity:	
Social Security Number (Optional):		
Home Phone No:	Work No:	
E-mail Address:		
Residential Address:		
Mailing Address:		
<b>B. <u>Name of Children:</u></b>		
Please list names of your natural/adopted children from oldest to youngest. Use an additional sheet of paper if necessary:		
<b>1. Name:</b>	Date of Birth:	
Name of School:	Grade:	
Work Place, if applicable:		
Occupation:		
Residential Address: (City & State)		
<b>2. Name:</b>	Date of Birth:	
Name of School:	Grade:	
Work Place, if applicable:		
Occupation:		
Residential Address: (City & State)		
<b>3. Name:</b>	Date of Birth:	
Name of School:	Grade:	
Work Place, if applicable:		
Occupation:		
Residential Address: (City & State)		
<b>4. Name:</b>	Date of Birth:	
Name of School:	Grade:	
Work Place, if applicable:		
Occupation:		
Residential Address: (City & State)		
<b>5. Name:</b>	Date of Birth:	
Name of School:	Grade:	
Work Place, if applicable:		
Occupation:		
Residential Address: (City & State)		
<b>6. Name:</b>	Date of Birth:	
Name of School:	Grade:	

Work Place, <i>if applicable</i> :	
Occupation:	
Residential Address: (City & State)	
<b>7. Name:</b>	Date of Birth:
Name of School:	Grade:
Work Place, <i>if applicable</i> :	
Occupation:	
Residential Address: (City & State)	
<b>8. Name:</b>	Date of Birth:
Name of School:	Grade:
Work Place, <i>if applicable</i> :	
Occupation:	
Residential Address: (City & State)	
<b>9. Name:</b>	Date of Birth:
Name of School:	Grade:
Work Place, <i>if applicable</i> :	
Occupation:	
Residential Address: (City & State)	
<b>10. Name:</b>	Date of Birth:
Name of School:	Grade:
Work Place, <i>if applicable</i> :	
Occupation:	
Residential Address: (City & State)	
<b>C. <u>Marital Background:</u></b>	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
If other than married, are you presently in a relationship? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If married, is this your first marriage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If No, number of previous marriages: _____	
<b>D. <u>Family Background:</u></b>	
<b>Name of Father:</b>	
Age:	Is Father still living? <input type="checkbox"/> Yes <input type="checkbox"/> No
If No, please indicate the date, age and cause of death:	
Residential Address of Father:	
Occupation:	
<b>Name of Mother:</b>	
Age:	Is Mother still living? <input type="checkbox"/> Yes <input type="checkbox"/> No
If No, please indicate the date, age and cause of death:	
Residential Address of Mother:	
Occupation:	
Are your parents married? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, how many years have your parents been married?	
If No, how many years have they been divorced or in a relationship?	
If divorced, did they remarry? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Siblings (Brothers and Sisters) - Please list the names of your siblings from oldest to youngest. Use an additional sheet of paper if necessary:</b>	
<b>1. Name:</b>	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:

Deceased <input type="checkbox"/> Alive <input type="checkbox"/> If deceased, cause of death:	
<b>2. Name:</b>	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased <input type="checkbox"/> Alive <input type="checkbox"/> If deceased, cause of death:	
<b>3. Name:</b>	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased <input type="checkbox"/> Alive <input type="checkbox"/> If deceased, cause of death:	
<b>4. Name:</b>	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased <input type="checkbox"/> Alive <input type="checkbox"/> If deceased, cause of death:	
<b>5. Name:</b>	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased <input type="checkbox"/> Alive <input type="checkbox"/> If deceased, cause of death:	
<b>6. Name:</b>	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased <input type="checkbox"/> Alive <input type="checkbox"/> If deceased, cause of death:	
<b>7. Name:</b>	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased <input type="checkbox"/> Alive <input type="checkbox"/> If deceased, cause of death:	
<b>8. Name:</b>	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased <input type="checkbox"/> Alive <input type="checkbox"/> If deceased, cause of death:	
<b>9. Name:</b>	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased <input type="checkbox"/> Alive <input type="checkbox"/> If deceased, cause of death:	
<b>10. Name:</b>	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased <input type="checkbox"/> Alive <input type="checkbox"/> If deceased, cause of death:	
<b><u>E. Educational Background:</u></b>	
Last Grade completed:	When:
Where:	
Post Secondary Education:	
Address (City & State):	
Name of College or University:	
Degree earned:	When completed:
Address (City & State):	
Name of College or University:	
Degree earned:	When completed:
Address (City & State):	
Name of College or University:	

Degree earned:		When completed:	
<b>F. <u>Employment Background:</u></b>			
Please list employment history starting with the most recent:			
<b>1. Name of Business or Govt. Agency:</b>			
Address (City & State):			
Position Title:			
Contact No:			
Length of Employment:			
<b>2. Name of Business or Govt. Agency:</b>			
Address (City & State):			
Position Title:			
Contact No:			
Length of Employment:			
<b>3. Name of Business or Govt. Agency:</b>			
Address (City & State):			
Position Title:			
Contact No:			
Length of Employment:			
<b>4. Name of Business or Govt. Agency:</b>			
Address (City & State):			
Position Title:			
Contact No:			
Length of Employment:			
<b>5. Name of Business or Govt. Agency:</b>			
Address (City & State):			
Position Title:			
Contact No:			
Length of Employment:			
<b>G. <u>Military History:</u></b>			
Have you ever enlisted in the United States Military? [ ] Yes [ ] No			
If Yes, what branch of military?			
Date of Enlistment :		Years of Service:	
Date of Discharge or Retirement:	Type of Discharge:	Rank:	
<b>H. <u>Religion Background:</u></b>			
What is your religious affiliation?			
What religious activities do you participate in?			
Do you encourage your children to practice your religion? [ ] Yes [ ] No			
<b>I. <u>Criminal History:</u></b>			
Do you have a history as an offender of Substance Abuse, Sexual Abuse, Child Abuse, and/or Family Violence? [ ] Yes [ ] No			
If Yes, please provide dates and places:			
Have you ever been <b>arrested</b> of Substance Abuse, Sexual Abuse, Child Abuse, and/or Family Violence? [ ] Yes [ ] No			
If Yes, please provide dates and places:			
Have you ever been <b>convicted</b> of Substance Abuse, Sexual Abuse, Child Abuse, and/or			

Family Violence?     Yes     No  
 If Yes, please provide dates and places:

Have you and/or your spouse (*if applicable*) ever been a subject of an unfavorable social study?  
 Yes     No  
 If Yes, provide dates and places:

**J. Household Composition:**

Please list all persons living in the home *other* than you and your children. Use an additional sheet of paper if necessary:

Name	Date of Birth	Relationship

**THE INFORMATION GIVEN BY ME IN THIS SOCIAL STUDY QUESTIONNAIRE FORM IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.**

**FAILURE TO DISCLOSE OR COOPERATE ON THE INFORMATION PROVIDED ABOVE MAY RESULT IN AN INCOMPLETE SOCIAL STUDY REPORT.**

\_\_\_\_\_ **Signature of Applicant**

\_\_\_\_\_ **Date**

