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Social History

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Personal History

Name: _____ Gender: □ Male □ Female

Address:_____
Street & Number City State Zip

Country of Origin: _____ Preferred Language: _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
Email: _____

Present Marital Status:

- □ Single, never married
- □ Married
- □ Separated
- □ Living with a Partner
- □ Divorced
- □ Widowed
- □ Other (specify) _____

Number of Children: _____ Ages of Children: _____

Who currently lives in your home?

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What type residence do you live in? (House, Apartment, Mobile home, Group home, Nursing home, etc.)
_____

If married, are you living with your spouse at present? Yes □ No □
If married, years married to present spouse: _____

What is your means of financial support? _____
What means of transportation do you have available? _____

Have you ever served in the military? Yes □ No □
What branch? _____ Number of years of service: _____
Honorable discharge? Yes □ No □

What resources or agencies in the community do you use to assist you in any way? _____
_____
_____
_____

Are you receiving counseling services at present? Yes □ No □
If yes, please briefly describe: _____
_____

Do you have a history of a diagnosed psychiatric disorder? Yes □ No □
Name of disorder: _____
Please describe treatment that was helpful to you in the past: _____
_____
What is (are) your main reason(s) for this visit? _____
_____
How long has this/have these problem(s) persisted? _____
_____
What is currently causing you stress? _____
_____

Medical History

Name and address of your primary physician: Physician's name: _____
Address: _____
Phone number: _____

Current medical conditions: _____
Family history of medical conditions: _____
_____
Have you had any recent changes in your sleep pattern? (Describe)_____
_____
Have you experienced any weight loss or weight gain? (Describe)_____
_____
Do you have any problems with hearing, vision, or speech? Describe)_____
_____
In the last 4 weeks have you had difficulty with any of the following?

Dressing self	Yes □ No □	Feeding self	Yes □ No □
Walking alone	Yes □ No □	Bathing self	Yes □ No □
Frequent falls	Yes □ No □	Getting out of bed	Yes □ No □
Swallowing your food	Yes □ No □	Playing sports	Yes □ No □

Current Medications:

Medication	Dosage	Last time taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies to foods or medications? Please list:

_____

_____

Are you experiencing any physical pain? Yes □ No □ (If yes, please answer the following questions):

Where is your pain located? _____

What makes the pain worse? _____

What makes the pain better? _____

How does your pain affect your lifestyle? _____

_____

What physician manages your pain symptoms? _____

Circle the severity of your pain on the scale below:

1 2 3 4 5 6 7 8 9 10

Least Pain **Most Pain**

Cultural/Spiritual/Social Needs

Do you have any cultural needs that we can address or that you feel may influence your treatment?

_____

_____

Are you currently involved with a religious organization, church, or synagogue?

Yes □ No □ If so, please name: _____

Current level of involvement in your religion: Minimal □ Sporadic □ Regular □ Very Active □

Do you have a belief in a Spiritual Being or Higher Power? Yes □ No □

Who do you consider your support systems to be? _____

_____

What kind of activities do you share with friends or family? _____

_____

What kind of activities do you enjoy for recreation or relaxation? _____

_____

Do you have any legal charges pending? Yes □ No □ If yes, what are they?

_____

Court Date: _____

Are you now, or have you ever been on probation? Yes □ No □ If yes, when? _____

What were the charges? _____

Family History

Mother's age _____ If mother is deceased, how old were you when she died? _____
Father's age _____ If father is deceased, how old were you when he died? _____
Number of sibling's _____ their ages: _____ _____ _____ _____ _____ _____

Were you adopted or raised by someone other than your birth parents? Yes □ No □
If yes, by whom and at what age? _____
Briefly describe your relationship with your family of origin _____
_____
Whom do you consider to be your family now? _____

Did your parents have any physical or mental health problems that you feel may have affected your childhood? Please describe: _____
_____

Was either parent diagnosed with a psychiatric mental health disorder? Yes □ No □
If so, name the(se) disorder(s):_____
Were they ever hospitalized? Yes □ No □
Are there any other family members with a diagnosed mental health disorder? Yes □ No □
If so, indicate their relationship to you and the name of their disorder:
_____
_____

Symptoms

Check the behaviors and symptoms that you experience more often than you desire:

- □ aggression
- □ alcohol use/dependence
- □ anger
- □ antisocial behavior
- □ anxiety
- □ avoiding people
- □ chest pain
- □ depression
- □ disorientation
- □ distractibility
- □ dizziness
- □ drug use/dependence
- □ eating disorder
- □ elevated mood
- □ fatigue
- □ hallucinations
- □ heart palpitations
- □ high blood pressure
- □ hopelessness
- □ impulsivity
- □ judgement impaired
- □ judgment errors
- □ loneliness
- □ memory impairment
- □ mood shifts
- □ panic attacks
- □ phobias/fears
- □ recurring thoughts
- □ sexual difficulties
- □ sick often
- □ sleeping problems
- □ speech problems
- □ suicidal thoughts
- □ thoughts disorganized
- □ trembling
- □ withdrawing
- □ worrying
- □ other (specify)
- □ _____
- □ _____
- □_____
- □ _____

Please give examples of how each of the symptoms that you checked above impairs your ability to function (socially, emotionally, occupationally, physically, etc.).

_____
_____
_____
_____

Self-Harm/Suicide Assessment

Do you have a history of suicide attempts? Yes □ No □
If yes, please describe this history: _____
_____
When was the last time you thought about suicide or felt suicidal? _____
What do you usually do when you have these thoughts/feelings? _____
_____
Do you ever hurt your body by activities such as cutting, burning, scratching too hard, etc.? Yes □ No □
If yes, describe the last time you did this: _____
_____
Do you consider self-harm a problem for you? Yes □ No □
Have you ever been treated for this problem? Yes □ No □

Current Alcohol and/or Drug Use

Do you use alcohol or recreational drugs? Yes □ No □ Ever had Detox? Yes □ No □

Please complete the following chart identifying any history of substance use:

Substance used	Age at 1st use	Current amount used	Last use and amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any family history of substance abuse (alcohol, recreational drugs, or prescription medications)? If yes, please explain: _____
_____

Have you ever experienced any withdrawal symptoms? Yes □ No □
If yes, describe: _____

Are drugs/alcohol related to any of the current stressors/problems in your life? Yes □ No □
(Describe)_____
_____

What treatment programs have been helpful to you in the past? _____
_____

History of Abuse

Have you ever been a victim of violence or abuse? Yes □ No □

If yes, please check below the forms of abuse that you experienced:

□ Physical □ Emotional □ Verbal □ Mental □ Sexual □ Rape

How old were you at the time of the abuse? _____

Did you receive treatment? Yes □ No □ Please explain:_____

Have you ever abused another person physically, sexually, verbally or emotionally? Yes □ No □

If yes, please explain: _____

What do you do when you get angry? _____

Identify Your Strengths

□ Has leisure skills/hobbies
□ Good work skills
□ Good physical health
□ Positive relationships
□ Education
□ Can think clearly
□ Capable of independent values and opinions
□ Motivated for treatment
□ Ability to make decisions
□ Assertiveness
□ Employment
□ Religious faith
□ Sense of humor
□ Other (describe) _____
□ Ability to express feelings
□ Positive support network
□ Insight
□ Available transportation
□ Cooperative
□ Ability to use community resources

List your areas of need for greatest improvement: _____

_____

List your main social difficulties: _____

_____

List your main difficulties at school or work: _____

_____

List your main difficulties at home: _____

_____

Additional information you believe would be helpful: _____

_____

Thank you for providing us with this information so that we may better assist you.

Completed by: _____ Date: _____