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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
- Walking alone Yes No
- Frequent falls Yes No
- Swallowing your food Yes No

- Feeding self Yes No
- Bathing self Yes No
- Getting out of bed 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? _____

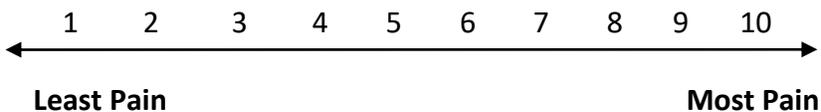
What makes the pain worse? _____

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:



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:

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

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 1 st 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

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

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: _____