



Social History Adult

Name: _____ Age: _____ Sex: _____ Today's Date: _____

Birth Date: _____ Birth Place: _____ Where did you grow up: _____

Current Marital Status: (check one) _____ Married _____ Widowed _____ Separated
_____ Single (Never married) _____ Divorced
_____ Unmarried Couple
List your children and their current ages in birth order:

PHYSICAL HEALTH:

Physician: _____ Height: _____ Weight: _____ Date of last exam? _____

List medications and dosages you're currently taking _____

Do you have any allergies? _____ No _____ Yes If yes, explain _____

In the past 2 weeks were your sleep patterns (Check one) _____ Typical or _____ Unusual
Check all that apply: _____ Nightmares _____ Insomnia _____ Early morning waking _____ Difficulty falling asleep _____ Restless

In the past 2 weeks were your daily eating habits (Check one) _____ Typical or _____ Unusual
Check all that apply: _____ 1-2 meals _____ 2-3 meals _____ snacks

Do you have any current or past eating disorders? _____ No _____ Yes If yes, explain _____

Do you have any current or past sexual problems? _____ No _____ Yes If yes, explain _____

Are you presently experiencing emotions and/or moods that affect your day to day functioning?
(Check one) _____ Never _____ Seldom _____ Often (6 times a year)
(Check all that apply) _____ Anxiety _____ Frustration _____ Manic states _____ Depression

COUNSELING HISTORY:

Have you had any prior counseling? _____ No _____ Yes If yes, describe _____

List any support groups you attend _____

Is there a family history of (Check all that apply) _____ Alcoholism _____ Substance Abuse _____ Mental Illness
Has anyone in your family been treated for a psychiatric disorder? _____ No _____ Yes If yes, explain _____

DRUG/ALCOHOL HISTORY:

Have you ever used alcohol and/or drugs to change or alter your behavior or mood? _____ No _____ Yes
If yes, explain: _____

Have you ever been charged with DWI/DUI? _____ No _____ Yes If yes, please explain _____

Complete the following for family members who use or have a history of alcohol/drug abuse

Table with 4 columns: Family Member, Substance Used, Current Use (yes or no), Treatment Received. Includes Patient Name and Client id fields.

FAMILY & SOCIAL HISTORY

FATHER: *Please answer questions as it was during your childhood*

Occupation _____ Highest Level of Education _____

Emotional Health __ Good __ Fair __ Poor Physical Health __ Good __ Fair __ Poor

Describe your father/child relationship _____

MOTHER: *Please answer questions as it was during your childhood*

Occupation _____ Highest Level of Education _____

Emotional Health __ Good __ Fair __ Poor Physical Health __ Good __ Fair __ Poor

Describe your mother/child relationship _____

With whom did you live during your childhood? _____

List brothers and sisters (including you) in birth order and give their current ages:

Describe your childhood (*Check one*) __ Happy __ Unhappy __ Mixed

Explain _____

Describe your adolescence (*Check one*) __ Happy __ Unhappy __ Mixed

Explain: _____

Were you abused? __ No Yes __ (*Check all that apply*) __ physically __ emotionally __ verbally __ sexually

EDUCATIONAL HISTORY

Indicate your highest level of education _____

Did you have difficulty in school? __ Yes or __ No If yes, explain _____

Describe any specialized skills for which you have training, certification or licensure

VOCATIONAL STATUS

Describe your employment history for the past five years beginning with your current position

Employer	Position	Time in Job	Reason for leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any physical/emotional problems that prevent your being employed

JOB PERFORMANCE

Has your employer or supervisor ever expressed any of the following concerns to you? (*Check all that apply*)

Patient Name _____

Client id _____

Missing too much work Assigned tasks not completed Irresponsibility
 Poor/bad attitude Difficulty getting along with others Late too often
 Attitude/behavior change Difficulty getting along with supervisors Increased errors

MILITARY HISTORY

Have you ever served in the military service? No Yes If yes when? From _____ To _____
Which branch _____ Rank at discharge _____
Did you ever serve in combat? No Yes If yes, describe _____

LEGAL HISTORY

Do you have any pending legal action? No Yes If yes, please explain _____

Are you currently on probation and/or parole? No Yes If yes, please explain _____

LEISURE, RECREATIONAL INTERESTS & HOBBIES

Would you consider your life as *(Check Yes or No for each area)*

Work oriented	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family oriented	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Self oriented	<input type="checkbox"/> Yes	<input type="checkbox"/> No	People oriented	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leisure oriented	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recreation oriented	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Activities you enjoy doing by yourself _____

Activities you enjoy with your family _____

Activities you enjoy with your friends _____

Do you have physical limitations that prevent exercise or physical activity? No Yes
If yes, what are they? _____

Do you exercise on a regular basis? No Yes

If yes how many times per week? *(Check one)* 1-2 times 3-4 times 5+ times

Are you able to separate drug and/or alcohol use from your activities? No Yes Sometimes

CHURCH ATTENDANCE

Do you attend church? No Yes If yes, where _____

How often do you attend? *(Check one)* Regularly Occasionally Seldom Never

SPIRITUAL HISTORY

The following information will contribute to the therapist's understanding of your spirituality.

Patient Name _____

Client id _____

It is our intent to be sensitive to your personal beliefs without imposing our doctrinal perspective.

While growing up, did you attend church? ___No ___Yes If yes, what and how important a part of family life was it? _____

Briefly describe your present involvement in your church _____

Are spiritual issues or resources important to you in therapy? If yes, explain briefly _____

I would describe God as . . . _____

I think God sees me as . . . _____

How is your relationship with God right now? _____

The most positive religious experience I have had is . . .

The most negative religious experience I have had is . . . _____

Have there been any significant changes in your spiritual life or perceptions within the past year?

If yes, please explain briefly _____

Please add any additional information or comments that you feel might be significant below...

Patient Signature _____ Date _____

Patient Name _____

Client id _____

Patient Name _____
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Client id _____
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