Patient Information & Social History- Adult

Name ____ **Today's Date** ______________
Last First MI

Address ____

Home Phone _______________ **Work Phone** _______________ **Cell** _______________

SS# _____________ **Birth Date** __________ **Age** _____ **Sex** ____ **Height** _____ **Weight** _____

Occupation ___________________ **Employer** ___________________ **Phone** ___________

Employer Address ____

Current Marital Status *(check one)* ___ Single (Never Married) ___ Married Years Married: ________

___ Widowed ___ Separated ___ Divorced ___ Unmarried/Cohabitating Couple

If Married, Spouse ____________________________ **Age** ________ **Phone** ______________

Spouse's Address ____

Spouse's Occupation __________________ **Employer**: ___________________________

Emergency Contact Name ______________________________ **Relationship** ______________

Emergency Contact Phone Number(s) ____

List the members of your family and all others living in your home

Name	Current Age/Birth date	Relationship

Client id______________

Please check any of the following problems that pertain to you:

___Nervousness	___Depression	___Fears	___Shyness
___Sexual Problems	___Suicidal Thoughts	___Separation	___Divorce
___Finances	___Drug Use	___Alcohol Use	___Friends
___Anger	___Self-Control	___Unhappiness	___Sleep
___Stress	___Work	___Relaxation	___Headaches
___Legal Matters	___Memory	___Ambition	___Energy
___Insomnia	___Tiredness	___Making Decisions	___Loneliness
___Inferiority Feelings	___Insomnia	___Education	___Career Choices
___Health Problems	___Temper	___Nightmares	___Marriage
___Children	___Appetite	___Stomach Trouble	
___Bowel Troubles	___Being a Parent	___My Thoughts	

HEALTH HISTORY

Primary Care Physician_________________________________ **Phone** ____________________________

Address ____

Date of last visit ____________________ **Current Health Problems** ______________________________

List all current medications and dosages ____

Do you have any allergies? ___ No ___ Yes **If yes, describe** ___________________________________

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**__________________

____

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

Previous Psychiatric or Psychological Services: ____Yes ___ No

Treatment Provider: ____ **Phone:** __________________

Address: ____

Reason you were seeking care: ____

Treatment outcome: ____

List any support groups you attend ____

Client id_______________

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

Family Member	Substance Used	Current Use (yes or no)	Treatment Received

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? ________________________**Where did you grow up** _____

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

Client id________________

EDUCATIONAL HISTORY

Indicate your highest level of education ____

Did you have difficulty in school? ___ Yes ___ 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)*

____ Missing too much work
____ Poor/bad attitude
____ Attitude/behavior change
____ Assigned tasks not completed
____ Difficulty getting along with others
____ Difficulty getting along with supervisors
____ Irresponsibility
____ Late too often
____ 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	____ Yes	____ No	Family oriented_	____ Yes	____ No
Self oriented	____ Yes	____ No	People oriented	____ Yes	____ No
Leisure oriented	____ Yes	____ No	Recreation oriented	____ Yes	____ No

Activities you enjoy doing by yourself ____

Client id________________

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, please describe? ____

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 / alcohol use from your activities? ___ No ___ Yes ___ Sometimes ___ NA

CHURCH ATTENDANCES *(This is section is optional)*

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.
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, 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? ___ No ___Yes 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____

____

____

Client id________________