Eden Counseling Center

Patient Information & Social History- Adult

Name _____ **Today's Date** _____

Last **First** **MI**

Address _____

Phone (Home): _____ **(Work)** _____ **(Cell)** _____

SS# _____ **Birth Date** _____ **Age** _____ **Sex** _____

Occupation _____ **Employer** _____

Employer Address _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separate ☐ Living with Partner

If Married, Spouse Name _____ **Age** _____ **Phone** _____

Emergency Contact Name _____ **Relationship** _____

Emergency Contact Phone Number(s) _____

Primary Care Physician _____ **Phone** _____

Address _____

COUNSELING HISTORY

Have you ever seen a Therapist before ☐ Yes ☐ No Name of Therapist _____

Have you ever seen a Psychiatrist before ☐ Yes ☐ No Name of Psychiatrist _____

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

Name	Current Age/Birth date	Relationship

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

- ☐ Nervousness
- ☐ Anger
- ☐ Depression
- ☐ Suicidal Thoughts
- ☐ Hopelessness
- ☐ Memory
- ☐ Sleep
- ☐ Fatigue
- ☐ Insomnia
- ☐ Nightmares
- ☐ Stress
- ☐ Headaches
- ☐ Decreased Appetite
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Health
- ☐ Low Energy
- ☐ Excessive Energy
- ☐ Sexual Problems
- ☐ Inferiority Feelings
- ☐ Loneliness
- ☐ Separation
- ☐ Unhappiness
- ☐ Relaxation
- ☐ Ambition
- ☐ Making Decisions
- ☐ Education
- ☐ Work
- ☐ Career Choices
- ☐ Finances
- ☐ Legal Matters
- ☐ Marriage Divorce
- ☐ Children
- ☐ Friends

HEALTH HISTORY

List all current medications and dosages _____

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

Treatment Provider: _____ **Phone:** _____

Address: _____

Reason you were seeking care: _____

Treatment outcome: _____

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

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

EDUCATIONAL HISTORY

Highest level of education

Did you have difficulty in school? ☐ Yes ☐ No If yes, explain

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/probation/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 _____

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 perweek? *(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

Briefly describe your present involvement in your church _____

Are spiritual issues or resources important to you in therapy? ☐ No ☐ Yes