



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 _____

Emergency Contact Name _____ Relationship _____

Address _____ Phone _____

Occupation _____ Employer _____ Phone _____

Employer Address _____

Current Marital Status (check one) _____ Single (Never Married) _____ Married Years Married: _____
_____ Widowed _____ Separated _____ Divorced _____ Unmarried/Cohabiting Couple

If Married, Spouse _____ Age _____ Phone _____

Spouse's Address _____

Spouse's Occupation _____ Employer: _____

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

| Name | Current Age/Birth date | Relationship |
|------|------------------------|--------------|
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| | | |
| | | |

Patient Name _____

Client id _____

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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fears | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Separation | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Finances | <input type="checkbox"/> Drug Use | <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Friends |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Self-Control | <input type="checkbox"/> Unhappiness | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Work | <input type="checkbox"/> Relaxation | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Legal Matters | <input type="checkbox"/> Memory | <input type="checkbox"/> Ambition | <input type="checkbox"/> Energy |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Tiredness | <input type="checkbox"/> Making Decisions | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Inferiority Feelings | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Education | <input type="checkbox"/> Career Choices |
| <input type="checkbox"/> Health Problems | <input type="checkbox"/> Temper | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Marriage |
| <input type="checkbox"/> Children | <input type="checkbox"/> Appetite | <input type="checkbox"/> Stomach Trouble | |
| <input type="checkbox"/> Bowel Troubles | <input type="checkbox"/> Being a Parent | <input type="checkbox"/> 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 _____

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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

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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)*

- | | | |
|---|--|---|
| <input type="checkbox"/> Missing too much work | <input type="checkbox"/> Assigned tasks not completed | <input type="checkbox"/> Irresponsibility |
| <input type="checkbox"/> Poor/bad attitude | <input type="checkbox"/> Difficulty getting along with others | <input type="checkbox"/> Late too often |
| <input type="checkbox"/> Attitude/behavior change | <input type="checkbox"/> Difficulty getting along with supervisors | <input type="checkbox"/> 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 _____

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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 _____

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