

**New Client Social History**  
**Keystone Counseling Solutions LLC**

**Personal Data** (Please copy and/or make corrections from Informed Consent form)

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Date of Evaluation:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**1. PRESENTING CONCERN & GOALS**

**Person Completing this form:** \_\_\_\_\_

**Primary Reason for Seeking Treatment:** \_\_\_\_\_

**What concerns have you been experiencing?** \_\_\_\_\_

**MENTAL HEALTH HISTORY**

Currently experiencing or identify past history:

	Not at all	Mild	Moderate	Severe
Feelings of sadness	_____	_____	_____	_____
Loss of interest or pleasure in activities	_____	_____	_____	_____
Lack of energy / tiredness	_____	_____	_____	_____
Poor/disturbed sleep	_____	_____	_____	_____
Putting on/losing weight	_____	_____	_____	_____
Poor concentration / forgetfulness	_____	_____	_____	_____
Slowness	_____	_____	_____	_____
Restlessness	_____	_____	_____	_____
Decreased interest in sex	_____	_____	_____	_____
Physical aches/pains	_____	_____	_____	_____
Believing that you are no good	_____	_____	_____	_____
Feelings of hopelessness	_____	_____	_____	_____
Thoughts of harming oneself	_____	_____	_____	_____
Feelings of guilt/self blame	_____	_____	_____	_____

	Not at all	Mild	Moderate	Severe
General feelings of nervousness	_____	_____	_____	_____
Psychological worry	_____	_____	_____	_____
Fear of loss of control	_____	_____	_____	_____
Fear of dying	_____	_____	_____	_____
Fear of going crazy	_____	_____	_____	_____
Feelings of unreality	_____	_____	_____	_____
Physical Trembling/jittery	_____	_____	_____	_____
Tightness / pain in the chest	_____	_____	_____	_____
Shortness of breath / choking	_____	_____	_____	_____
Sweating	_____	_____	_____	_____
Pounding heart	_____	_____	_____	_____
Hot and cold flushes	_____	_____	_____	_____

Not at all    Mild    Moderate    Severe

Dizziness / light-headedness \_\_\_\_\_

Sweating \_\_\_\_\_

Alternating periods of Depressed and Elevated Mood \_\_\_\_\_

Intense happiness or joy, feeling "high" or overly excitable \_\_\_\_\_

Fast speech: racing thoughts \_\_\_\_\_

Impulsive, high risk behaviors \_\_\_\_\_

Need for little to no sleep and function \_\_\_\_\_

Unrealistic ideas of grandeur (feels invincible, super powers, capable of unrealistic things) \_\_\_\_\_

Easily Distracted \_\_\_\_\_

Problems with disorganization \_\_\_\_\_

Loses things easily \_\_\_\_\_

Experience Traumatic Event \_\_\_\_\_

Avoidance of specific places, situations, etc. due to anxiety \_\_\_\_\_

Frequent Nightmares or Flashbacks \_\_\_\_\_

Exaggerated Startle Response \_\_\_\_\_

Hyper Vigilance or Hyper Scanning \_\_\_\_\_

Hear or See things that are not there \_\_\_\_\_

Restriction of Eating/Bulimic Behavior \_\_\_\_\_

Difficulty with Anger/Aggression \_\_\_\_\_

Other:

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Have you ever attempted suicide/self harm? Yes No \_\_\_\_\_

Have you ever had a Plan to die by suicide? Yes No \_\_\_\_\_

Past Mental Health Treatment Interventions (i.e. Counseling/Hospitalizations. Please list Addiction Tx under "Substance Abuse History" Please include diagnosis if you know them):

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**Current Psychotropic Medications**

Medication	Purpose	Dosage	Frequency

**2. SOCIAL HISTORY**

**Significant life events:**

Ages birth to 5: \_\_\_\_\_

Ages 6-10: \_\_\_\_\_

Ages 11-15 \_\_\_\_\_

Ages 16-20 \_\_\_\_\_

Ages 21-30 \_\_\_\_\_

Ages 31 to present \_\_\_\_\_

How old were your parents when you were born? \_\_\_\_\_ Mother \_\_\_\_\_ Father

With whom did you live as a child? \_\_\_\_\_

Please list relationships and the ages during which you lived with them (ex: foster parents, grandparents, etc.) \_\_\_\_\_

Was your family troubled by any of the following problems while you were growing up?

- a.) alcoholism b.) illness c.) poverty d.) mental illness e.) unemployment
- f.) trouble with the law g.) divorce h.) frequent moves i.) none

If so, briefly describe

\_\_\_\_\_

How would you characterize your childhood? (Answer all that apply)

- a.) happy b.) frightening c.) unhappy d.) dull e.) hard to remember
- f.) secure g.) painful h.) regimented i.) uneventful

Rate your family's economic status during childhood and adolescence:

- a.) poverty level (received welfare) b.) working class c.) middle class
- d.) upper middle class e.) wealthy

What were your favorite activities during your childhood?

\_\_\_\_\_

Which descriptions characterize you as a child?

- a.) outgoing b.) shy c.) active d.) awkward e.) irresponsible
- f.) nervous g.) rebellious h.) serious i.) stubborn j.) unhappy
- k.) calm l.) temperamental m.) self-confident

What were problems for you as a child?

- a.) getting along with mother b.) getting along with father c.) getting along with sibling(s)
- d.) getting along with peers e.) getting along with teachers f.) bed wetting
- g.) nightmares h.) excessive fears or worries i.) felt I was a burden to my parents
- j.) overweight k.) underweight l.) having my feelings hurt
- m.) fear of failure n.) none

How would you describe your mother's discipline?

- a.) Strict b.) Fair c.) Lenient d.) Inconsistent

How would you describe your father's discipline?

- a.) Strict b.) Fair c.) Lenient d.) Inconsistent

How were you disciplined as a child?

- a.) Spanked b.) Grounded c.) Scolded d.) Wasn't disciplined e.) Other

Were you ever spanked or punished in a way that left marks on you? \_\_\_\_\_ No \_\_\_\_\_ Yes

Were you ever verbally abused as a child? (Example: told you were stupid, dumb or ugly?)

Did you ever run away from home? \_\_\_\_\_ No \_\_\_\_\_ Yes

What are the most vivid memories you have about your childhood?

At what age did you leave your childhood home and why?

Environmental Influences (moves and reasons, housing and environmental conditions that might affect condition or life):

Did you have intimate/close friends during childhood? \_\_\_\_\_ No \_\_\_\_\_ Yes

Do you have intimate/close friends now? \_\_\_\_\_ No \_\_\_\_\_ Yes

Who is in the support system, and is there a comfortable amount of support?

## PARENT AND FAMILY HISTORY

What city did you live in while growing-up? \_\_\_\_\_

How was the relationship between your parents? \_\_\_\_\_

If your parents were married, was there any history of separations or divorce? Yes No

If yes, explain: \_\_\_\_\_

**Father Name:** \_\_\_\_\_

Which descriptions characterize you father (paternal care taker)

- a.) warm b.) distant c.) uncaring d.) domineering e.) unpleasant f.) overprotecting  
g.) rejecting h.) strict i.) abusive j.) fault finding k.) understanding l.) affectionate

Is he living? If so age? \_\_\_\_\_ If no, how old was he when he died? \_\_\_\_\_

Highest Education level? \_\_\_\_\_

What is (was) his usual line of work? \_\_\_\_\_

How many times did he marry? \_\_\_\_\_

History of excessive alcohol or drug abuse? Yes No If yes, explain: \_\_\_\_\_

History of legal problems? Yes No If yes, explain: \_\_\_\_\_

History of emotional problems (mental illness)? Yes No If yes, explain: \_\_\_\_\_

**Mother Name:** \_\_\_\_\_

Which descriptions characterize your mother (maternal care taker)

- a.) warm b.) distant c.) uncaring d.) domineering e.) unpleasant f.) overprotecting  
g.) rejecting h.) strict i.) abusive j.) fault finding k.) understanding l.) affectionate

Is she living? If so, age? \_\_\_\_\_ If no, how old was she when she died? \_\_\_\_\_

Highest level of education? \_\_\_\_\_

What is (was) her usual line of work? \_\_\_\_\_

How many times did she marry? \_\_\_\_\_

History of excessive alcohol or drug abuse? Yes No If yes, explain: \_\_\_\_\_

History of legal problems? Yes No If yes, explain: \_\_\_\_\_

History of emotional problems (mental illness)? Yes No If yes, explain: \_\_\_\_\_

How would you describe your parents (or parent substitute) relationships with each other?

- a.) ideal b.) violent c.) indifferent d.) full of conflict e.) hot and cold f.) reserved  
g.) distant h.) happy i.) domineering/submissive j.) loving k.) hostile

What did your parents argue about?

- a.) money b.) discipline of children c.) relatives interfering d.) drinking e.) sex  
f.) jealousy g.) not taking care of home h.) not being a good provider i.) never argued

Where do your parents currently reside? \_\_\_\_\_

**Stepparent Name:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

Current age: \_\_\_\_\_ Year married to parent: \_\_\_\_\_

If deceased, at what age did they die? \_\_\_\_\_

Describe stepparent: \_\_\_\_\_

Highest educational level attained: \_\_\_\_\_

Occupation: \_\_\_\_\_

History of excessive alcohol or drug abuse? Yes No If yes, explain: \_\_\_\_\_

History of legal problems? Yes No If yes, explain: \_\_\_\_\_

History of emotional problems (mental illness)? Yes No If yes, explain: \_\_\_\_\_

Primary method of discipline: \_\_\_\_\_

What are the ages and relationships (oldest to youngest) of your brothers and sisters?  
Name, Age, Gender, Relationship (other relevant information of married/single/ #children,  
where they reside)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Which descriptions characterize how you got along with your brothers and sisters as a child?  
a.) quarrelsome b.) distant c.) indifferent d.) close e.) other

How do you get along with your brothers and sisters now?

\_\_\_\_\_

**For each sibling please identify any issues with the following:**

History of mental illness? Yes No If yes, explain: \_\_\_\_\_

History of alcohol or drug abuse? Yes No If yes, explain: \_\_\_\_\_

History of criminal behavior? Yes No If yes, explain: \_\_\_\_\_

Any moderate to high conflict or stress with any sibling? Yes, NO If yes,  
explain \_\_\_\_\_

At what age did you start dating? \_\_\_\_\_

How many different boyfriends/girlfriends did you have in high school? \_\_\_\_\_

How many long-term relationships (6 months or longer) have you had? \_\_\_\_\_

Currently:

\_\_\_\_\_ Single, but involved in intimate relationship \_\_\_\_\_ Single

\_\_\_\_\_ Married

\_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed

How many times have you been married? \_\_\_\_\_

If previously divorced what was the reason(s): \_\_\_\_\_

Length of present marriage \_\_\_\_\_ Age when married \_\_\_\_\_ Spouse's age \_\_\_\_\_

Do you and your spouse differ in attitudes on any of the following?

- a.) sexual matters b.) leisure activities c.) religion d.) finances
- e.) use of alcohol or drugs f.) women's role in the family g.) raising children h.) infidelity
- i.) men's role in family j.) spouse's occupation \_\_\_\_\_

Have you ever been physically, verbally, or sexually abused by your spouse?

\_\_\_\_\_ No \_\_\_\_\_ Yes If yes, briefly explain: \_\_\_\_\_

Do you have children? \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, are any of these children by a previous marriage? \_\_\_\_\_

Please indicate by placing H for husband's and a W for wife's next to the name of the child.

Please List Name Gender/Age DOB School/Grade Living in the home/Out of Home

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Do your children have any special concerns? \_\_\_\_\_ No \_\_\_\_\_ Yes

\_\_\_\_\_ Behavioral \_\_\_\_\_ Emotional

\_\_\_\_\_ Physical \_\_\_\_\_ School

If yes, which child and briefly explain

Have you or your spouse ever had an abortion, miscarriage, or stillbirth? \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, briefly explain:

Have you or your spouse ever been accused of child abuse? \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, briefly explain

## PHYSICAL HEALTH HISTORY

How would you describe your general level of health? Excellent Good Fair Poor

Are you currently under the care of a physician? \_\_\_\_\_ No \_\_\_\_\_ Yes If yes, briefly explain:

Any Current Symptoms: Asthma Cancer Diabetes Hypertension Arthritis Headaches  
Insomnia TB Bleeding Allergies or Other:

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Do you eat a balanced diet? \_\_\_\_\_ No \_\_\_\_\_ Yes

Do you exercise regularly? \_\_\_\_\_ No \_\_\_\_\_ Yes

Do you have a family history of cancer, heart trouble, diabetes? \_\_\_\_\_ No \_\_\_\_\_ Yes

Have you ever experienced any of the following problems:

- a.) fatigue b.) loss of consciousness c.) head traumas d.) seizures
- e.) dizziness f.) headaches g.) asthma h.) musculoskeletal pain
- i.) vision trouble j.) fainting k.) hives l.) ulcers
- m.) allergies n.) hearing trouble o.) nausea or vomiting p.) abdominal pains
- q.) bowel problems r.) Dysmenorrhea s.) Tachycardia—palpitations t.) loss of feeling-tingling

Past Physical Health History (any significant illnesses, injuries or surgeries): None Reported

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### Current Non-Psychotropic Medications

Medication	Purpose	Dosage	Frequency
None Reported by Client			

### 5. ACADEMIC/INTELLECTUAL/WORK HISTORY

Elementary School: \_\_\_\_\_ District: \_\_\_\_\_

Middle School: \_\_\_\_\_ District: \_\_\_\_\_

High School: \_\_\_\_\_ District: \_\_\_\_\_

Number of suspensions from school: \_\_\_\_\_

Did you graduate from high school? Yes No If yes, when? \_\_\_\_\_

Grade point average in high school \_\_\_\_\_

Sports or clubs you participated in school: \_\_\_\_\_

Did you receive any tutoring, counseling, or special education assistance during your schooling? Yes No If yes, explain: \_\_\_\_\_

Did you have any conduct or discipline issues with school? \_\_\_\_\_

Please list any post-high school training:

School: \_\_\_\_\_ Date \_\_\_\_\_ to \_\_\_\_\_

Type of Training or Major \_\_\_\_\_

Degree: \_\_\_\_\_ Grade Point Average: \_\_\_\_\_

School: \_\_\_\_\_ Date \_\_\_\_\_ to \_\_\_\_\_

Type of Training or Major \_\_\_\_\_

Degree: \_\_\_\_\_ Grade Point Average: \_\_\_\_\_

How is your financial situation at this time? (circle one) Terrible Fair Good Very Good

Are you concerned about debt other than mortgage or car payments? \_\_\_\_\_

Are you under any particular financial stress? No Yes If yes, briefly explain: \_\_\_\_\_



Have you ever filed for bankruptcy? Yes No  
At this time, are you able to pay bills and provide essential needs for your children? Yes No  
If no, explain:

Do you gamble? Yes No If so, describe:

Family's primary source of income: \_\_\_\_\_ My earning \_\_\_\_\_ Relatives  
\_\_\_\_\_ Welfare \_\_\_\_\_ Spouse's earnings \_\_\_\_\_ Disability \_\_\_\_\_ Other

**EMPLOYMENT HISTORY**

\_\_\_\_\_ Employed \_\_\_\_\_ Unemployed \_\_\_\_\_ Retired \_\_\_\_\_ Disabled \_\_\_\_\_ Never employed  
Name of company \_\_\_\_\_ Job title \_\_\_\_\_  
Company address \_\_\_\_\_  
Phone \_\_\_\_\_  
Length of employment \_\_\_\_\_ Hours \_\_\_\_\_  
Are you satisfied with your present job? \_\_\_\_\_ No \_\_\_\_\_ Yes  
If no, briefly explain: \_\_\_\_\_  
Briefly describe job duties: \_\_\_\_\_  
What type of jobs have you performed in the past?

Length of longest job? \_\_\_\_\_  
Have you ever been fired or laid off? \_\_\_\_\_ No \_\_\_\_\_ Yes If yes, describe \_\_\_\_\_

**MILITARY HISTORY**

If you have ever been in the military, circle the branch that applies:

USA, USN, USCG, USMC, USAF, USPHS

Length of service \_\_\_\_\_ Highest rank \_\_\_\_\_ Why did you enlist? \_\_\_\_\_

APR or OER Ratings: \_\_\_\_\_ Most Recent \_\_\_\_\_  
Job Title: \_\_\_\_\_ Briefly describe job duties \_\_\_\_\_

Have you ever received any disciplinary action including LOC, LOR, Article 15, Court Martial? Circle all that apply and briefly explain: \_\_\_\_\_

Type of discharge: \_\_\_\_\_ Are you eligible for VA benefits? \_\_\_\_\_ No \_\_\_\_\_ Yes

**6. MEDICAL and DEVELOPMENTAL HISTORY (Client as childhood)**

Physical development (delays/interruptions etc.): \_\_\_\_\_

Prenatal, birth, developmental milestones, prenatal exposure to alcohol & tobacco:

History of injuries and illnesses, handicapping conditions: \_\_\_\_\_

SEXUAL HISTORY (If age relevant)

Briefly describe your parent’s attitude toward sex \_\_\_\_\_

At what age did you become sexually active? \_\_\_\_\_

Have you ever had any traumatic sexual experience? (Such as sexual molestation, rape, etc.)

\_\_\_\_\_ No \_\_\_\_\_ Yes If yes, briefly explain \_\_\_\_\_

Is your present sex life satisfactory? \_\_\_\_\_ No \_\_\_\_\_ Yes If no, briefly explain:

\_\_\_\_\_ Sexual development, menstrual history, pregnancies, births, or fathered children if relevant:

\_\_\_\_\_ Sexual Orientation (if age appropriate): Hetero Gay Bi-Sex N/A

**7. LEGAL HISTORY**

Have you ever been detained or arrested? Y N

Have you ever been charged with a crime? Y N

Have you ever been convicted of a crime? Y N

Were you ever in jail or prison? Y N

If yes to any above, please explain: \_\_\_\_\_

If current please include probation/parole/diversion etc. \_\_\_\_\_

Has your driver’s license ever been suspended? Y N

**8. VICTIM ISSUES**

Have you had any homicidal or violent thoughts towards others? Y N

Have you had any violent/assaultive behaviors towards others? Y N

Have you ever had a PFA filed against you? Y N

Have you ever at any time had violent/assaultive behaviors towards others? Y N

If “YES” to any of the above, When: \_\_\_\_\_

Explain:

\_\_\_\_\_

Have you ever been a victim of any of the following and if yes, please explain:

A). Physical Abuse: B). Sexual Abuse: C) Emotional Abuse: D) Neglect: E). Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**9. SUBSTANCE ABUSE HISTORY**

Do you smoke cigarettes? Have you in the past? When did you start? quit? How much?

\_\_\_\_\_

Which of the following have you used?

a.) Acid (LSD) b.) Methamphetamine (Crank) c.) MOMA (Ecstasy)

d.) Steroids e.) Inhalants (Gas, Paint, Airplane glue)

f.) GHB (Gamma-hydroxybutyrate) g.) Benzodiazepines (Xanax, Ativan, Valium)

h.) Opioids (Codeine, Darvon, Vicodin, Dilaudid, Demerol, Heroin) i.) Ritalin j.) Marijuana

k.) Quaaludes (Sedative/Hypnotics) l.) Cough medicine m.) Cocaine n.) Hallucinogenics

o.) Barbiturates (Central Nervous System depressants – “Downers” p.) Tranquilizers

q.) PCP r.) Other s. s) None How Often? \_\_\_\_\_

What type of alcohol beverages do you enjoy? \_\_\_\_\_  
 How often do you consume alcoholic beverages (average)? \_\_\_\_\_  
 How much alcohol do you usually consume when drinking? \_\_\_\_\_  
 How many times have you been intoxicated (drunk) during the past year (once or twice, once a month, once a week, several times a week, daily, never)? \_\_\_\_\_  
 Have you ever experienced black outs from consuming alcohol? Yes No  
 Has anyone ever expressed concern about your alcohol consumption? Yes No  
 If so, who and why? \_\_\_\_\_  
 Have you ever received a DUI (driving under the influence) conviction? Yes No  
 If so, explain: \_\_\_\_\_  
 Did you ever sell drugs? Yes No  
 Have you ever attended AA or received therapy for substance abuse? Yes No  
 If so, explain: \_\_\_\_\_  
 Info on use of any other substance with same above questions? \_\_\_\_\_

Periods of Abstinence (when and why?): \_\_\_\_\_  
 Do you believe that you are an Addict/Alcoholic? Y N  
 Experienced (circle)? Detox      Overdose      Sweats      Shakes      Convulsions  
    Seizures      DT's      Hallucinations      Passing Out      Hangovers      Memory Loss  
 Blackouts      Other: \_\_\_\_\_

Influence of living situation on your Use?: \_\_\_\_\_

Other Addictive Behavior (Gambling/Sex/Pornography/Video Games/Eating/Risk Taking)  
 Other: \_\_\_\_\_

**Consequences of Use:** Legal    Job    Relationships    Family    Financial    Other: \_\_\_\_\_

**10. PERSONAL ASSETS AND LIABILITIES**

Strengths (Abilities) that will help achieve your goals:

Limitations or roadblocks: \_\_\_\_\_  
 \_\_\_\_\_

RECREATIONAL/LEISURE

What do you do for fun? \_\_\_\_\_

Is finding a way to enjoy these activities hard for you? \_\_\_\_\_ No \_\_\_\_\_ Yes If yes, briefly explain: \_\_\_\_\_

Do you belong to any clubs, groups, or organizations? \_\_\_\_\_ No \_\_\_\_\_ Yes  
 Names: \_\_\_\_\_

Are there any activities you want to be involved in but don't know how? \_\_\_\_\_ No \_\_\_\_\_ Yes  
 If yes, briefly explain \_\_\_\_\_

Spiritual Beliefs/Religious Affiliation if relevant

Were you raised according to a certain religious faith? Yes No If so, explain: \_\_\_\_\_

What is your current religious affiliation? \_\_\_\_\_

Do you attend services on a regular basis? Yes No

Do you follow or believe any other sort of spiritual dynamic? Please explain : \_\_\_\_\_

Are religious or spiritual issues an area of controversy in the raising of the children? Yes No

If yes, please describe: \_\_\_\_\_

**CULTURAL BELIEFS**

Do you consider yourself to be part of any cultural or ethnic group? (Example: Italian, Black, Native American) \_\_\_\_\_ No \_\_\_\_\_ Yes briefly explain \_\_\_\_\_

Is there anything about your cultural beliefs of which you would like your therapists to be aware? \_\_\_\_\_ No \_\_\_\_\_ Yes briefly explain \_\_\_\_\_

**11. COLLATERAL INFORMATION: \_\_\_\_\_**

\_\_\_\_\_

Diagnosis and Goals (Reviewed with client)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

(5/18)