LYNNE MOSER, LCSW

Social History

_____
Today's date

Client's Name: _____ Birthdate: _____ Age: _____

Occupation: _____ Employer: _____ Marital status: _____

I. **Family:** Please list immediate family members and other significant individuals.

Name	Birthdate	Age	Yrs of Education Or highest degree	Occupation	Lives in the home?
Spouse / partner					
Son / daughter					
Son / daughter					
Son / daughter					
Brother / sister					
Brother / sister					
Brother / sister					
Parent					
Parent					
Other					

a. Have there been major upsets or significant changes in family life or family structure (birth, death, divorce, adoption, foster placement, recent move, etc.)? Explain. _____

_____

_____

b. Are there other significant people in your life? (friends, co-workers, church members, other relatives, etc.)? Explain.

_____

_____

c. How do members of the family get along? Explain. _____

_____

___ Asthma
___ Cancer
___ PTSD
___ Hypertension
___ Eating disorder
___ Anxiety disorder
___ High cholesterol
___ Kidney disease

___ Heart disease
___ Alcoholism
___ Drug addiction
___ Depression
___ *Bipolar disorder*
___ Schizophrenia
___ STD's
___ ADD / ADHD

___ Allergies
___ Diabetes
___ Thyroid disease
___ Arthritis
___ *Lupus*
___ Emphysema
___ Sleep apnea
___ Insomnia

a. Any hospitalizations? When and why? _____

b. Are there any genetic conditions or illnesses that have affected your health and development? Explain. _____

c. Past and present medication use (when, reason prescribed, dosage, side effects, etc.) _____

d. Who is your medical doctor? _____

e. Do any members of the family have major illnesses or chronic health problems? Explain _____

III. Educational

a. What level of education have you completed?_____ college major? _____

b. Did you experience any learning or adjustment problems at any level of school (pre-school, primary, elementary, middle, high school, college, graduate school)? Explain _____

IV. **Social:** Please any of the following events that have occurred in our life and indicate the date or estimated time period for each item checked. You may use the "Comments" column to briefly describe how these events impacted you.

Event	Check if "yes"	Date	Comments
Death of a parent			
Natural disaster			
Trauma *(war, addiction, abuse, crime victimization, etc.)*			
Unwed pregnancy			
Physical abuse / domestic violence			
Sexual molestation / assault/ rape			
Physical assault			
Death of a close friend			
Discovery of being adopted			
Separation/divorce of parents			
Incarceration of parent(s)			
Incarceration of other family member(s)			
Juvenile delinquency			
Alcohol/drug use or addiction			
Loss of job			
Victim of crime / bullying / stalking			
Postpartum struggles (females)			
Loss of a child			
Legal problems / incarceration			
Financial problems *(bankruptcy, foreclosure, etc.)*			

V. **Family:** Any family members with a history of the following conditions?

	Depression	Schizophrenia	Bipolar Disorder	Substance Abuse/Addiction	Anxiety	Trauma *(due to military service, addiction, abuse, crime victimization, etc.)*
Parent						
Sibling						
Children						
Aunt/Uncle						
Grandparent						

Explain any of the above checked boxes:_____

_____

_____

VI. Mental and Emotional Health

1. How would you describe your mental and emotional health at this time? Poor Fair Good Very Good Excellent

2. Have you ever received therapy or counseling for emotional or mental problems? Yes No If yes, please list dates, reasons, therapist(s):

_____

_____

_____

3. Have you ever (now or in the past) taken medication for emotional problems? Yes No If yes, pleaselist medications and dates:

_____

_____

4. Have you ever been hospitalized for emotional problems? Yes No If yes, what are hospital, dates, and reason?

_____

_____

5. Current stressors in your life: _____

_____

_____

6. Have you ever purposely injured or cut yourself? Yes No If yes, please explain: _____

_____

_____

7. Have you ever had suicidal thoughts, plans or attempts? Yes No If yes, when and why? _____

_____

_____

VII. SUBSTANCE ABUSE

1. Do you consume alcoholic beverages? _____How often? _____

2. How much alcohol do you usually consume when drinking? _____

3. How many times have you been drunk or high during the past year? _____ During the past five years? _____

4. Have you ever experienced alcohol or drug induced black outs? Yes No If yes, please describe when and where:

_____

_____

5. Has anyone ever expressed concern about your alcohol and/or drug use? Yes No If yes, who and why?

_____

_____

6. Have you ever been arrested or convicted for DUI (driving under the influence)? Yes No If yes, explain:

_____

_____

7. What types of drugs have you used: (check those that apply)

____ marijuana	____ methamphetamine	____ PCP
____ powder cocaine	____ bath salts	____ mescaline
____ crack cocaine	____ spice	____ crank
____ LSD	____ K2	____ other (_____)
____ heroin	____ prescription meds	____ other (_____)

8. If any of the above are checked, please describe the age you started using the drug and amount of usage:

_____

_____

9. Have you ever sold or manufactured drugs? Yes No describe: _____

_____

10. Have you ever been to AA/NA, drug/alcohol rehab or therapy for addiction or substance use? Yes No If yes, explain:

_____

_____

VII. Other Relevant Information: Please use this space to provide any other information that you think may be relevant to your current issues and why you are pursuing help at this time:

_____

_____

_____

_____