THE BRAIN CENTER

5605 Princeton Ave. Ste A, Columbus, GA 31904 • Office: (706) 221-0112   Fax: (706) 221-0114

Adult Outpatient Psychosocial History

Name: ____

Date of Birth: _____________ Age: _____ Gender: _____________ Race: __________________

Referral Source: Self _______ Physician (name) __________________ Other _______________

Reasons for Seeking Treatment:
I am seeing treatment at this time because:

____

____

____

____

I have been having problems since ____

My family/others want me to seek treatment because: _____________________________________

____

____

____

Family History:
Current marital status of my parents:
_____ Married _____ Divorced _____Separated _____Widowed _____Single Parent

My father's age, if living _____________________
His occupation __________________________ His highest education _______________________

His health status ____

If deceased, his age at death and cause of death ________

Your age when he died __________________

My mother's age, if living ______________________

Her occupation _________________________ Her highest education _______________________

Her health status ____

If deceased, her age at death and cause of death _______________________________________

Your age when she died __________________

My siblings:

Brother/Sister	Age	Occupation	Hx of Mental Illness/Addictions
			Yes or No (circle one)
			Yes or No (circle one)
			Yes or No (circle one)
			Yes or No (circle one)

Do you have stepparents? _____ Yes _____No
If yes, rate your current relationship with them __Tense __Close __No contact at all
__ Very Close __ Distant __Other____________

Rate your current relationship with your biological parents __Tense __Close __No contact at all
__ Very Close __ Distant __Other____________

Rate your current relationship with your siblings __Tense __Close __No contact at all
__ Very Close __ Distant __Other____________

Rate your current relationship with your extended family __Tense __Close __No contact at all
__ Very Close __ Distant __Other____________

Developmental History:
To my knowledge, I had a normal birth, delivery, and normal early childhood development (that is, I walked, talked, etc., about on time). _____Yes _____No
If no, please explain:

____

____

____

Education:

I completed the _____ grade or _____years of college with a degree in _______________________

Did you like school? _____Yes _____No _____Somewhat

Did you get good grades? _____Yes _____No _____Somewhat

What were (are) your strengths and weaknesses in school?

Strengths ____

Weaknesses ____

If currently in school, which school? ____

Any grade failures? ____

Were you ever diagnosed with a learning disability? _____ Yes _____No

Were you ever diagnosed with attention deficit disorder or hyperactivity? _____Yes _____No

Any history of behavior problems, I.e. suspensions, truancy, fighting? _____Yes _____No

If yes, please explain

____

____

____

____

Employment:

I am employed _____Yes _____No

I am employed with ____

My job title is ____________________________________ Years Employed ________________

Summaries Employment History ____

Is your employer aware of a need for treatment? _____Yes _____No

If yes, does your employer have any special requirement for you to return to work?___Yes ___No

Finances:

Do you have a problem with managing money? _____Yes _____No

Are you currently experiencing financial distress? _____Yes _____No

Please comment ____

____

Social/Leisure:

Leisure activities I enjoy, and how often I participate in them

Type	How often

My level of interest in these activities has changed lately. _____Yes _____No

How are these changes and your problem related? ____

____

____

I have enough close friends who provide me with support. _____Yes _____No
Please comment: ____

____

Marital Information:
Marital status: _____Married _____Single, never married _____Divorced _____Widowed
Spouse's name: __________________________Age, if living ________ Occupation________________

Health status: ____

If deceased, age at death and cause of death ____

Years married __________
Relationship with spouse: _____Satisfactory _____Unsatisfactory _____Needs Improvement

Please comment ____

My spouse has a history of mental illness: _____Yes _____No
My spouse has a history of addiction: _____Yes _____No
If previously married, state how long you were married, and reason the relationship ended.
How long married ______________ Reason for ending ________________________________

____

____

My children and step-children from all relationships:

Name	M/F	Age	Relationship with me	Comments
			❑ Satisfactory ❑ Unsatisfactory	
			❑ Satisfactory ❑ Unsatisfactory	
			❑ Satisfactory ❑ Unsatisfactory	
			❑ Satisfactory ❑ Unsatisfactory	

Living Situation:
I currently live with ____

Other people living in my house (if any) are: ____

____

I live in a _____House _____Apartment _____Trailer that I _____Own _____Rent

If other living accommodations are used, please describe: ___________________________________

____

Military History:

Branch of service: ___________________________ Number of years served___________

Rank at discharge: __________________________

Type of discharge: _____Honorable _____Dishonorable _____Medical _____Other

Comments on your time of service, including promotions, demotions, problems, successes, etc.

____

____

Legal History:

Do you have an arrest record (including DUIs)? _____Yes _____ No

Is yes, please explain: ____

Date	Type of Offense	Result

Are there any other legal involvements (pending suits, bankruptcy, custody issues)?

_____Yes _____No

If yes, please explain ____

____

Psychiatric:

I have problems with depression _____Yes _____No

I have problems with anxiety _____Yes _____No

Describe any other problems: ____

____

Previous inpatient or outpatient treatment _____Yes _____No

Date	Where	Treatment/Medications Prescribed

Alcohol and Drug History

I have abused alcohol: _____Yes _____No

If yes, complete the following.

My pattern of use is ____

The last time I had a drink was ________________ . I have used alcohol ____ months/years.

I have periods while drinking that I cannot remember: ___ Yes ___ No

I have experienced jitteriness, anxiety, or nervousness when I don't drink: ___Yes ___No

I have abused drugs (including prescription drugs): _____Yes _____No

If yes, complete the following:

Type: ____

My pattern use is: ____

My last use was: _____________________I have used drugs for ____ months/years.

History of withdrawal symptoms: ____

____

My drinking and/or drug use has had an effect on the following life areas:

___ Family ___Social ___Legal ___Job ___Physical ___Financial ___Emotional

Previous inpatient or outpatient treatment for drugs and/or alcohol: _____Yes ____No

Dates	Where	Treatment/Medications Prescribed

Any involvement in AA, NA, support groups, etc? ____

Trauma:

Any abuse (verbal, physical, or sexual)? If so, when? ___________ By Whom_________________

Any natural disasters (fire, tornado, earthquake, etc.)? ________ If so, when? __________________

Any deaths or major losses? ________ If so, when? _______________________________________

Any other trauma? ___________ If so, when? ____

Medical:

Any chronic/current medical problems? _____Yes _____No

If yes, please explain: ____

Any allergies? _____Yes _____No

If yes, please explain: ____

Any surgeries? _____Yes _____No

If yes, please explain: ____

I am currently taking the following medications: ______________________________________

____

Date of last physical examination? _______________ Doctor's name_______________________

Results of examination: ____

____

____ ______________________

Client's Signature Date