

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
			<input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory	
			<input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory	
			<input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory	
			<input type="checkbox"/> Satisfactory <input type="checkbox"/> 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

If 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