**Psychosocial History**

Instructions: To assist me in helping you, please fill out this form as fully and openly as possible. All information is private and held in strictest confidence within legal limits. If certain questions do not apply to you, mark NA. If you need more space for any answer please use the back of that sheet.

**Personal Information**

Client’s name: Date:

Gender: F M Date of birth: Age:

Form completed by (if someone other than client):

 Address: City: State:

Zip:

Phone (home): (cell): Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Counseling History**

How did you hear about my services, or who referred you?

 Are you receiving counseling services at present? Yes\_\_\_\_\_No

 If Yes, please briefly describe:

 Have you received counseling in the past? Yes \_\_\_\_\_No

 If Yes, please briefly describe:

 What is (are) your main reason(s) for this visit?

 How long has this problem persisted?

 Under what conditions do your problems usually get worse?

 Under what conditions are your problems usually improved?

What are your goals for therapy?

Do you feel suicidal at this time or have you had previous suicide attempts or thoughts?

 \_\_\_\_\_Yes \_\_\_\_\_No

If Yes, explain:

Has any family member had outpatient psychotherapy? \_\_\_\_\_Yes \_\_\_\_\_No

If yes, who/why (list all):

 Have you had prior inpatient treatment for a psychiatric, emotional, or substance use disorder?

\_\_\_\_\_Yes \_\_\_\_\_No

If Yes, explain:

Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder?

\_\_\_\_\_Yes \_\_\_\_\_No

If Yes, explain:

Has any family member used psychotropic medications?

\_\_\_\_\_Yes \_\_\_\_\_No

If yes, who/why (list all):

**Medical/Physical Health**

(Mark current or past)

 AIDS Dizziness Nose bleeds

 Alcoholism Drug abuse Pneumonia

 Abdominal pain Epilepsy Rheumatic Fever

 Abortion Ear infections Sexually transmitted diseases

 Allergies Eating problems Sleeping disorders

 Anemia Fainting Sore throat

 Appendicitis Fatigue Scarlet Fever

 Arthritis Frequent urination Sinusitis

 Asthma Headaches Small Pox

 Bronchitis Hearing problems Stroke

 Bed wetting Hepatitis Sexual problems

 Cancer High blood pressure Tonsillitis

 Chest pain Kidney problems Tuberculosis

 Chronic pain Measles Toothache

 Colds/Coughs Mononucleosis Thyroid problems

 Constipation Mumps Vision problems

 Chicken Pox Menstrual pain \_\_\_\_ Vomiting

 Dental problems Miscarriages Whooping cough

 Diabetes Neurological disorders Other (describe):

 Diarrhea Nausea

Name and phone number of your primary physician:

 Physician’s name:

 Phone number:

 List any major illnesses and/or operations you have had:

 List any physical concerns you are having at present (e.g., high blood pressure, headaches,

dizziness, etc.):

Current prescribed medications Dose Dates Purpose Side effects

Current over-the-counter meds Dose Dates Purpose Side effects

Family history of medical problems:

Pleases check if there have been any recent changes in the following:

 Sleep patterns Eating patterns Behavior Energy level

 Physical activity level General disposition Weight Nervousness/tension

Describe changes in areas in which you checked above:

On average how many hours of sleep do you get daily?

 Do you have trouble falling asleep at night? Yes\_\_\_\_\_\_No

 If Yes, describe:

Have you gained/lost over ten pounds in the past year? Yes No, gained\_\_\_lost

 If Yes, was the gain/loss on purpose? Yes \_\_\_\_\_\_No

 Describe your appetite (during the past week):

 poor appetite average appetite large appetite

**Eating behaviors**

Have you ever self induced vomited? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If so how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has this been going on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you restrict your food intake? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. How often do you restrict?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has this been going on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you binge eat? \_\_\_\_\_\_\_\_\_\_\_\_\_. How long has this been going on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much food do you consume in a binge? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chemical Use History**

 Method of Frequency Age of Age of Used in last Used in last

 use and amount of use first use last use 48 hours 30 days

 Yes No Yes No

Alcohol

Barbiturates

Valium/Librium

Cocaine/Crack

Heroin/Opiates

Marijuana

PCP/LSD/Mescaline \_\_\_

Inhalants

Caffeine

Nicotine

Over the counter

Prescription drugs

Other drugs

Substance of preference

 1. 3.

 2. 4.

**Substance Abuse Questions**

Describe when and where you typically use substances:

Describe any changes in your use patterns:

Describe how your use has affected your family or friends (include their perceptions of your use):

Reason(s) for use:

 Addicted Build confidence Escape Self-medication

 Socialization Taste Other (specify):

How do you believe your substance use affects your life?

Who or what has helped you in stopping or limiting your use?

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

 Yes No If Yes, describe:

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes No

If Yes, describe:

Have you had adverse reactions or overdose to drugs or alcohol? (describe):

Have drugs or alcohol created a problem for your job? Yes No

If Yes, describe:

**Spiritual/Religious**

How important to you are spiritual matters? Not Little \_\_\_\_ Moderate Much

Are you affiliated with a spiritual or religious group? Yes \_\_\_\_No

If Yes, describe:

Were you raised within a spiritual or religious group? Yes \_\_\_\_No

If Yes, describe:

 What is your present religious affiliation?

 1) Catholic

 2) Jewish

 3) Protestant (specify denomination if any)

 4) None, but I believe in God

 5) Atheist or agnostic

 6) Other (please specify)

How important is religious commitment to you?

 Unimportant Average importance Extremely important

 1 2 3 4 5 6 7

Do you desire to have your religious beliefs and values incorporated into the counseling process?

 Yes No Not sure (Please explain):

**Legal**

**Current Status**

Are you involved in any active cases (traffic, civil, criminal)? Yes \_\_\_\_No

If Yes, please describe and indicate the court and hearing/trial dates and charges:

Are you presently on probation or parole? Yes \_\_\_\_\_No

If Yes, please describe:

**Past History**

Traffic violations: Yes No DWI, DUI, etc.: Yes No

Criminal involvement: Yes \_\_\_\_No

Civil involvement: Yes \_\_\_\_No

If you responded Yes to any of the above, please fill in the following information.

 Charges Date Where (city) Results

**Education**

Fill in all that apply: Years of education: Currently enrolled in school? Yes \_\_\_\_No

 High school grad/GED

 Vocational: Number of years: Graduated: Yes \_\_\_\_No Major:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 College: Number of years: Graduated: Yes No Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Graduate: Number of years: Graduated: Yes No Major:

Other training:

Special circumstances (e.g., learning disabilities, gifted):

**Employment**

Begin with most recent job, list job history:

 Employer Dates Title Reason left the job How often miss work?

Currently: FT PT Temp Laid-off Disabled Retired

 Social Security Student Other (describe):

**Leisure/Recreational**

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

 Activity How often now? How often in the past?

**Family Of Choice Information**

Present marital status:

 1) Never married 5) Separated

 2) Engaged to be married 6) Not remarried

 3) Married now for first time 7) Widowed

 4) Divorced and remarried 8) other (specify)

 If married, are you living with your spouse at present? Yes\_\_\_\_\_\_No

If married, years married to present spouse:

Any marital problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If any children please answer the following: (if you need more room use the back of this sheet)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First Name | Age | Gender | Any problems in parenting or other areas with this child | If deceased date of death |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Any miscarriages or abortions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family Of Origin Information**

 Mother’s age: If deceased, how old were you when she died?

 Father’s age: If deceased, how old were you when he died?

 If your parents separated or divorced, how old were you then?

 Number of brother(s) Their ages:

 Number of sister(s) Their ages:

 I was child number in a family of children.

 Were you adopted or raised with parents other than your natural parents? Yes No

Briefly describe your relationship with your brothers and/or sisters:

Which of the following best describes the family in which you grew up?

 Warm and accepting Average Hostile and fighting

 1 2 3 4 5 6 7 8 9

Which of the following best describes the way in which your family raised you?

 Allowed me to be Attempted to

 very independent Average control me

 1 2 3 4 5 6 7 8 9

**Your Mother** (or mother substitute)

 Briefly describe your mother:

How did she discipline you?

 How did she reward you?

 How much time did she spend with you when you were a child?

 much average little

 Your mother’s occupation when you were a child:

 stayed home worked outside part-time worked outside full-time

 How did you get along with your mother when you were a child?

 poorly average well

How do you get along with your mother now?

 poorly average well

 Did you mother have any problems (e.g., alcoholism, violence, etc.) that may have affected your childhood development? Yes No

 If Yes, please describe:

Is there anything unusual about your relationship with your mother? Yes No

 If Yes, please describe:

**Your Father** (or father substitute)

 Briefly describe your father:

How did he discipline you?

 How did he reward you?

How much time did he spend with you when you were a child?

 much average little

 Your father’s occupation when you were a child:

 stayed home worked outside part-time worked outside full-time

How did you get along with your father when you were a child?

 poorly average well

 How do you get along with your father now?

 poorly average well

 Did you father have any problems (e.g., alcoholism, violence) that may have affected your

childhood development? Yes No

 If Yes, please describe:

 Is there anything unusual about your relationship with your father? Yes\_\_\_\_\_No

 If Yes, please describe:

**Development**

Are there special, unusual, or traumatic circumstances that affected your development? Yes\_\_No

If Yes, please describe:

Has there been history of child or adult abuse? Yes \_\_\_\_No

If Yes, which type(s)? Sexual \_\_\_\_Physical \_\_\_\_Verbal

If Yes, were you the: \_\_\_\_Victim \_\_\_\_Perpetrator

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other childhood issues: Neglect \_\_\_\_\_\_Inadequate nutrition\_\_\_\_\_Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments re: childhood development:

**Social Relationships**

Check how you generally get along with other people: (check all that apply)

 Affectionate Aggressive Avoidant Fight/argue often Follower

 Friendly Leader Outgoing Shy/withdrawn Submissive

 Other (specify):

Describe your friendship now and growing up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Sexual orientation: Comments:

Sexual dysfunctions? Yes \_\_\_\_\_No

If Yes, describe:

Any history of being a sexual perpetrator? Yes \_\_\_\_No

If Yes, describe:

How many sexual partners: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

What are your thoughts about sexuality and being a man or a woman: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Thoughts and Behaviors**

 Please check how often the following thoughts occur to you:

 1) Life is hopeless. Never Rarely Sometimes Frequently

 2) I am lonely. Never Rarely Sometimes Frequently

 3) No one cares about me. Never Rarely Sometimes Frequently

 4) I am a failure. Never Rarely Sometimes Frequently

 5) Most people don’t like me. Never Rarely Sometimes Frequently

 6) I want to die. Never Rarely Sometimes Frequently

 7) I want to hurt someone. Never Rarely Sometimes Frequently

 8) I am so stupid. Never Rarely Sometimes Frequently

 9) I am going crazy. Never Rarely Sometimes Frequently

 10) I can’t concentrate. Never Rarely Sometimes Frequently

 11) I am so depressed. Never Rarely Sometimes Frequently

 12) God is disappointed in me. Never Rarely Sometimes Frequently

 13) I can’t be forgiven. Never Rarely Sometimes Frequently

 14) Why am I so different? Never Rarely Sometimes Frequently

 15) I can’t do anything right. Never Rarely Sometimes Frequently

 16) People hear my thoughts. Never Rarely Sometimes Frequently

 17) I have no emotions. Never Rarely Sometimes Frequently

 18) Someone is watching me. Never Rarely Sometimes Frequently

 19) I hear voices in my head. Never Rarely Sometimes Frequently

 20) I am out of control. Never Rarely Sometimes Frequently

 Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thought that occur frequently or are a concern to you. Use the back of this sheet if necessary.

**Symptoms**

 Check the behaviors and symptoms that occur to you more often than you would like them to
take place:

 aggression fatigue sexual difficulties

 alcohol dependence hallucinations sick often

 anger heart palpitations sleeping problems

 antisocial behavior high blood pressure speech problems

 anxiety hopelessness suicidal thoughts

 avoiding people impulsivity thoughts disorganized

 chest pain irritability trembling

 depression judgment errors withdrawing

 disorientation loneliness worrying

 distractibility memory impairment other (specify)

 dizziness mood shifts

 drug dependence panic attacks

 eating disorder phobias/fears

 elevated mood recurring thoughts

 Please give examples of how each of the symptoms you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically). Use the back of this sheet if necessary.

List your five greatest strengths:

 1)

 2)

 3)

 4)

 5)

List your five greatest weaknesses:

 1)

 2)

 3)

 4)

 5)

 List your main social difficulties:

 List your main love and sex difficulties:

 List your main difficulties at school or work:

 List your main difficulties at home:

List your behaviors you would like to change:

Additional information you believe would be helpful: