**Adult Social History Information**

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**: \_\_\_\_\_\_ /\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:** \_\_\_\_\_\_ /\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Presenting Problem (Why are you seeking help at this time?):**

**How long have you struggled with this problem?** \_\_\_ past month only \_\_\_ last 1-3 months \_\_\_ 3-6 months

 \_\_\_ last 6-12 months \_\_\_ past 1-3 years \_\_\_ over 3 years

 \_\_\_ off and on for past \_\_\_ years

**Please check any of the following problems that you or your family have experienced which may have contributed to you seeking help:**

\_\_ Substance Use/Abuse \_\_ Anxiety \_\_ Guilt/Shame

\_\_ Family Conflict \_\_ Dating/Marriage Conflict \_\_ Relationship Stress

\_\_ Depression \_\_ Suicidal Thoughts \_\_ Anger Problems

\_\_ Work Problems \_\_ Legal Problems \_\_ Sexual Abuse

\_\_ Lying \_\_ Grief and Loss Issues \_\_ Emotional Abuse

\_\_ Health/Medical Problems \_\_ Parenting \_\_ Domestic Violence

\_\_ Eating Disorders \_\_ Childhood Trauma \_\_ Lack of Coping Skills

\_\_ Feeling Overwhelmed \_\_ Loneliness \_\_ Self-Esteem

\_\_ Spiritual Issues \_\_ Pornography \_\_ Divorce

\_\_ Other?

**Do you or anyone close to you have any concerns about safety including:**

 **\_\_\_** having thoughts of hurting yourself during the past 3 months

 \_\_\_ having thoughts of hurting someone else during the past 3 months

 \_\_\_ having thoughts of cutting on yourself

 \_\_\_ concerns about drinking or using drugs

**Have you had any previous psychiatric care including:** \_\_\_ I have seen a psychiatrist for medication management in the past

 \_\_\_ I’m currently seeing a psychiatrist or other provider for medication management

 \_\_\_ I have been hospitalized inpatient before

 Number of times \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Most recent admission date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Locations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TRAUMA HISTORY:**

Have you had any history of trauma including:

\_\_\_ Experienced physical abuse as child \_\_\_ Experienced sexual abuse as child \_\_\_ Experienced emotional abuse as child

\_\_\_ Experienced physical abuse as adult \_\_\_ Experienced sexual abuse as adult \_\_\_ Experienced emotional abuse as adult

\_\_\_ Have you had concussions before \_\_\_ Are you a war veteran \_\_\_ Have you experienced flashbacks

\_\_\_ Do you have frequent nightmares \_\_\_ Have you had a traumatic brain injury

**FAMILY PSYCHIATRIC HISTORY (Biological)**

\_\_\_ Is there any history of mental illness with biological parents or siblings? If so, please describe below any diagnoses or illness:

**MEDICAL CONDITIONS & HISTORY**

**Do you or any biological family members have any of the following medical problems? Use S= Self; M = Mother; F = Father; D = Daughter; Son = Son; X = Sibling;**

\_\_\_\_\_\_\_Asthma/Bronchitis \_\_\_\_\_\_\_Liver Problems \_\_\_\_\_\_\_Diabetes

\_\_\_\_\_\_\_Hyperactivity \_\_\_\_\_\_\_Stomach Problems \_\_\_\_\_\_\_Hepatitis

\_\_\_\_\_\_\_Hypertension \_\_\_\_\_\_\_Epilepsy \_\_\_\_\_\_\_HIV

\_\_\_\_\_\_\_Tuberculosis \_\_\_\_\_\_\_Cancer \_\_\_\_\_\_\_Heart Problems

\_\_\_\_\_\_\_Hospitalizations \_\_\_\_\_\_\_Accident-Related Injuries \_\_\_\_\_\_\_Migraines

\_\_\_\_\_\_\_Head Injuries \_\_\_\_\_\_\_Fibromyalgia

\_\_\_\_\_\_\_Other (list):

**Please list any medications that you are currently taking below:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** **Name** | **Why** **Prescribed?** | **Dose** **(mg’s/amount)** | **Frequency** **Taken** |
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**Are you allergic to anything?** \_\_\_ Yes \_\_\_ No

 Allergic to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Allergic to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Allergic to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Allergic to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUBSTANCE USE HISTORY:**

 Do you currently use alcohol? \_\_\_ Yes \_\_\_ No

 Do you currently use drugs? \_\_\_ Yes \_\_\_ No

 Do you have any concerns about your use of alcohol or drugs? \_\_\_ Yes \_\_\_ No

 Have you ever abused over the counter medication? \_\_\_ Yes \_\_\_ No

 Have you ever abused pain medications? \_\_\_ Yes \_\_\_ No

 Have you ever overused diet pills? \_\_\_ Yes \_\_\_ No

 During a month, how often do you drink alcohol?

\_\_\_ Not at all \_\_\_ Once a week or less \_\_\_ 1-2 times per week \_\_\_ More than 3 times per week

During a month, how often do you use marijuana?

\_\_\_ Not at all \_\_\_ Once a week or less \_\_\_ 1-2 times per week \_\_\_ More than 3 times per week

**FAMILY HISTORY:**

**Are you married or in a long-term relationship**? \_\_Yes \_\_ No \_\_\_Widowed **(If no or widowed, skip to next question)**

 Current partner’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date relationship began:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How long have you been together? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please circle how you would describe your relationship?

 Very Mostly Has Ups Not Very Very

 Healthy Good & Downs Good Unhealthy

 Do you have children together? \_\_\_ Yes \_\_\_ No If yes, please list names/ages below.

**Have you been married or in a long-term relationship previously?** If yes, please list the start and end of the relationship.

**Do you have siblings?** Yes No #of Brothers:\_\_\_\_\_ # of Sisters:\_\_\_\_\_

Your birth order in your family is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe your current relationship with your family:**

**Have you experienced any losses or significant deaths in your life?** \_\_ Yes \_\_No (if yes, how has this impacted you?)

**SOCIAL HISTORY:**

Do you have a close friend or friends that you can talk to when needed? \_\_\_ Yes \_\_\_ No

 Do you enjoy being involved in social events and gatherings with family? \_\_\_ Yes \_\_\_ No

 Do you enjoy being involved in social events and gatherings with friends? \_\_\_ Yes \_\_\_ No

 Do you enjoy being involved in public social events and gatherings? \_\_\_ Yes \_\_\_ No

 Do you consider yourself involved in a local church? \_\_\_ Yes \_\_\_ No

 Do you consider yourself spiritual or religious? \_\_\_ Yes \_\_\_ No

 Are you involved in any support groups or community groups? \_\_\_ Yes \_\_\_ No

**DEVELOPMENTAL HISTORY:**

 Did you have any developmental delays during your first 2 years? \_\_\_ Yes \_\_\_ No

 Did you have any problems reading, walking or talking during first 5 years? \_\_\_ Yes \_\_\_ No

**EDUCATIONAL/OCCUPATIONAL HISTORY:**

What is your highest education level completed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 GED? \_\_\_ No \_\_\_ Yes…………………………………………………………………….. Date Received\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 High School Attended\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 College Attended\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 College Attended\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any military service? \_\_\_ Yes \_\_\_No (if yes, branch :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**LEGAL HISTORY:**

 Do you have any current or upcoming legal charges? \_\_\_ Yes (list below) \_\_\_ No

 Do you have any previous legal charges, DUI’s or MIC’s/MIP’s? \_\_\_ Yes (list below) \_\_\_ No

 Are you currently on probation or parole? \_\_\_ Yes (list P.O. below) \_\_\_ No

**TREATMENT HISTORY:**

Have you ever been treated or evaluated for addiction related concerns? \_\_\_ Yes \_\_\_ No

Have you ever received inpatient or outpatient mental health treatment? \_\_\_ Yes \_\_\_ No

 **Please list Substance or Mental Health Treatment Facility Names Date of Treatment Reason**

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

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Please list any mental health diagnoses that you have received in the past:

What do you want to accomplish out of counseling?

 Is faith an important part of your life? If yes, please describe below. If no, please leave blank.

**Thank you for taking time to fill this out. This helps in the evaluation process, as well as providing additional information.**