ADULT SOCIAL HISTORY

General:

Name:_____Date:_____

Address:_____Home Phone:_____

City:_____Cell Phone:_____

Email:_____Date of Birth:_____

Referred by Whom:_____

If an insurance company:

Name of Insurance Co:_____Customer Service Number:_____

Subscriber Name:_____Subscriber #:

Group Number_____Authorization Number:_____

Marital Status: Married Divorced Single Educational Level:_____

Occupation:_____Employer:_____

Emergency Contact:_____

Patient Questionnaire/Intake Information:

CURRENT PROBLEM:

What brings you to counseling? Be as complete as possible.

_____
_____
_____
_____
_____
_____

Why have you decided to come for counseling at this time specifically? What has happened that makes you come now?

_____
_____
_____
_____

What would you like to change about yourself to make your situation better?

_____
_____
_____

FAMILY INFORMATION:

( )Single ( )Partnered ( )Married ( )Widowed ( )Separated ( )Divorced
Name of Spouse/Significant other:_____

Do you have any children? Y N How many?___Does your partner have children? Y N How many?____

Do the children live with you and your partner?_____ If so, please state names and ages_____
_____

Names and ages of children living with you or for which you are financially responsible?_____
_____

Names of others living with you and relationship to you:
Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Last grade completed:_____

Occupation:_____How long?_____

Employer:_____How long?_____

Have you ever been unable to work?_____How long?_____When?_____

Have you ever had periods of unemployment?_____How long?_____ When?_____

How many jobs have you had in the past 5 years?_____

Do you frequently miss work?____Did you serve in the military?____When?_____

MEDICAL INFORMATION

Do you have any medical problems? ___ If you do, when did they start?_____
_____
_____

Medications Currently taking	Dosage	When are they taken?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PSYCHOLOGICAL HISTORY

Previous Counselor	From – to	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized for psychiatric reasons?_____

Where?	When?
_____	_____
_____	_____
_____	_____

Have you ever been subjected to one or more psychological tests?_____

What tests?_____Name of Person who administered tests:_____
Address:_____
Phone :_____

Have you ever attempted suicide?_____When:_____
Describe the circumstances:_____

Are you currently having suicidal thoughts?_____Please describe:_____

Non-prescribed substances you use/d including alcohol, caffeine, tobacco, amphetamines, cocaine, marijuana, heroin, or others?

Substance	*Current amount & frequency*	*Past amount/frequency*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TREATMENT GOALS

What do you hope to gain for yourself out of your time utilizing counseling?

Any other information that you could add that you think might be helpful._____
_____
_____
_____
_____
_____

CURRENT SYMPTOM CHECKLIST

These symptoms may or may not be related to the problem which brings you to treatment. However, they help us plan your treatment.

( ) Trouble going to sleep
( ) Restless sleep
( ) Waking up early & being unable to Fall back to sleep
( ) Sleeping too much
( ) feeling guilty
( ) Depressive feelings that are regularly Worse in morning
( ) Thoughts of suicide
( ) Made suicide attempts
( ) Fatigue or loss of energy
( ) Poor concentration & memory
( ) Decreased sex drive
( ) Feelings of restlessness

( ) Loss of pleasure in usual activities
( ) Loss of appetite
( ) Feelings of worthlessness
( ) Weight Loss/gain
( ) Feelings of sadness or depression
( ) Uncontrollable habits
( ) Arguing with others
( ) Feelings people dislike you
( ) Wanting to be left alone

( ) Feeling bored with others

( ) Feeling alone even with others
( ) Others are inferior to you
( ) Other relationship problems
( ) Light headedness
( ) Trembling
( ) Muscle tension
( ) Shortness of breath
( ) Afraid of losing control

( ) Vomiting
( ) hot or cold spells
( ) numbness or tingling in parts of your body
( ) allergy problems
( ) high blood pressure
( ) menstrual irregularity or distress
( ) asthma attacks
( ) hives
( ) irritable bowels, constipation
( ) tics
( ) smoking
( ) overconsumption or sugar Sugar cravings
( ) eating disturbance
( ) frequent colds or flu
( ) minor accidents
( ) grinding teeth/jaw tension
( ) Withdrawing from others
( ) other:_____
( ) feeling critical of others
( ) feeling shy or uneasy
( ) difficulty communicating What you really feel or think
( ) feeling inadequate/less than Others
( ) others do not understand you
( ) other not meeting your needs
( ) palpitation
( ) sweating
( ) sense of dread
( ) chest pains
( ) cold, clammy hands
( ) avoiding certain situations