Adult Psychosocial History

Date______________________

Please provide the following information. It will assist us in getting to know you and your concerns. It will be held to the same standards of confidentiality as an appointment.

Name ____
First M.I. Last

Address____

____
City State Zip

Birth date__________/____________/____________

Home Phone:________________________________
May we leave a message? ☐Yes ☐No
Do you prefer calling for appointment reminders? ☐Yes ☐No

Cell Phone: ________________________________
May we leave a message? ☐Yes ☐No
Do you prefer texting for appointment reminders? ☐Yes ☐No

Email: ____________________________________
May we email you? ☐Yes ☐No
Do you prefer emailing for appointment reminders? ☐Yes ☐No

Relationship Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed

Gender: ☐Female ☐Male ☐Transgender ☐Gender Neutral

Emergency contact-please list the name, telephone number and relationship _________________

____

Referred by ____

Over please

Disability

Defined as substantially limiting movement, sensory, social, employment, or learning activities.
☐Yes ☐No ____

Ethnicity

☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Hispanic or Latino ☐Native Hawaiian or Pacific Islander ☐White
☐Multi-ethnic ____

Social Information

Please describe your primary support system (family, friends, support groups, church community, etc)

____

____

Do you identify as LGBTQ? ☐Yes ☐No

Education/Occupational Information

Are you currently employed? ☐Yes ☐No ☐On disability

If yes, name of current employer/position.____

Please indicate highest level of education.___________________

Degree, if applicable________________

Are you happy at your current position? ____

Please list any work-related stressors.____

If unemployed, how long have you been unemployed? ______________________________

Religious/Spiritual Information

Do you consider yourself to be a religious person? ☐Yes ☐No
Do you consider yourself to be a spiritual person? ☐Yes ☐No

If yes, what is your faith/religion/spiritual path?_______________________________________

Name: ________________________________

Legal History

Are you currently or have you ever been involved in any legal proceedings (SSD, traffic, divorce, civil, criminal)?
If yes, please describe____

Are you preparing for any legal proceedings? ☐Yes ☐No If yes, please explain_____________

Are you presently on probation or parole? ☐Yes ☐No If yes, please explain_______________

Mental Health History

Are you currently receiving any mental health treatment or prescribing services elsewhere?

☐Counseling: Name of counselor/agency: ____

☐Medications: Name of Prescriber: ____

Have you had previous counseling? ☐Yes ☐No

If yes, previous therapist's name ____

How long ago did you receive these services? ________________

Have you ever engaged in self-harming behavior? ☐Yes ☐No

Describe and when was last time: ____

Have you ever attempted suicide? ☐ Yes ☐ No When: ________________________________

Were you hospitalized for either self-harm or for an attempted suicide in the past? ☐ Yes ☐ No

What hospital: ______________________________________

In the last year, have you experienced any significant life changes or stressors (death of a loved one, divorce, loss of job, etc.)? ____

Have you experienced any traumatic events? ____

____

What coping strategies do you currently use and how effective are they?________________

What are your goals or concerns for therapy and/or medication management?

___

___

What do you consider to be your strengths?___

Family Mental Health History

Has anyone in your family (either immediate family or relative) experienced difficulties with the following? **Check any that apply and list family member** (sibling, parent, uncle, etc).

- ☐ Depression ___
- ☐ Anxiety ___
- ☐ Schizophrenia ___
- ☐ Eating Disorder ___
- ☐ Trauma ___
- ☐ Bipolar Disorder ___
- ☐ Panic Attacks ___
- ☐ Alcohol/Substance Abuse ___
- ☐ Completed Suicides ___
- ☐ ADHD ___

Health Information

Allergies: (List any meds, foods, etc.) ___

___

How would you describe your physical health at present?

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

Primary Care Provider___Phone #___

Date of last physical: ___

Please indicate if you experience now or in your history any of the following medical issues:

☐ Heart disease	☐ Seizures	☐ Pregnancy Issues
☐ Chronic Pain	☐ Diabetes	☐ Fibromyalgia
☐ Cancer	☐ Stroke	☐ Chronic Fatigue
☐ Thyroid Problems	☐ Hepatitis	☐ Urinary Tract Infections
☐ High Blood Sugar	☐ Migraines	☐ Binging/purging/food restriction
☐ Sleep Disturbances	☐ Premenstrual issues	☐ Unexplained weight fluctuations

Have you ever been hospitalized for any of these conditions and when: ___

___

Name: ________________________________

Please list all medications (including over-the counter/herbal remedies) and dosages.

Meds	Dosage
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

What do you do for physical activity:____

____

Substance Use

Do you use tobacco? ☐Yes ☐No How much per day: ______________________________

Do you use Caffeine? ☐Yes ☐No How much per day: ______________________________

Do you drink alcohol? ☐Yes ☐No How much per week: ____________________________

Do you engage in recreational/street drugs? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

What kind?____

Describe any history with recreational/street drugs: __________________________________

If applicable, describe any treatment obtained for addiction:_____________________________

____

Please check behaviors and symptoms that happen more often than you would like them to occur.

- ☐ Aggression
- ☐ Angry
- ☐ Concentration issues
- ☐ Crying spells
- ☐ Depressed Mood
- ☐ Disorientation
- ☐ Distractibility
- ☐ Dizziness
- ☐ Elevated mood
- ☐ Excessive purchasing
- ☐ Exposure to traumatic event(s)
- ☐ Fatigue/low energy
- ☐ Fearful
- ☐ Gambling concerns
- ☐ Grief
- ☐ Hallucinations
- ☐ Heart palpitations
- ☐ Homicidal thoughts
- ☐ Hopelessness
- ☐ Indecisiveness
- ☐ Isolating from friends/family
- ☐ Jealousy
- ☐ Judgment errors
- ☐ Loneliness
- ☐ Loss of interest in activities
- ☐ Memory impairment
- ☐ Inadequacy
- ☐ Insecurity
- ☐ Irritability
- ☐ Mood shifts
- ☐ Nightmares
- ☐ Obsessions
- ☐ Panic attacks
- ☐ Persistent urges or thoughts
- ☐ Physical discomfort
- ☐ Pornography concerns
- ☐ Racing thoughts
- ☐ Reckless or self-destructive
- ☐ Repetitive behaviors
- ☐ Restless or keyed up
- ☐ Revengeful
- ☐ Sadness
- ☐ Sexual addictions
- ☐ Sexual difficulties
- ☐ Shame/Guilt
- ☐ Shortness of breath
- ☐ Socially avoidant or isolating
- ☐ Stomachaches
- ☐ Suicidal thoughts
- ☐ Suspicious of others
- ☐ Tics
- ☐ Trembling
- ☐ Trauma
- ☐ Worrying excessively

- ☐ Other___________________________