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SOCIAL HISTORY QUESTIONNAIRE

Client's Name: _____ Client's DOB: ____/____/____ Age: ____ Sex: □M / □F
If different from above, what is the name of the person completing this form and what is your relationship to client?
_____

Medical / Physiological:
Name of PCP: _____ Phone / fax: _____
Most recent physical: _____
Please list, if any, illnesses, conditions, or previous diagnosis, whether physical or mental:_____
_____

Hospitalizations (physical & mental): _____
_____

Describe any significant developmental history: _____

Please list any medications you are currently taking along with the dosage(s) and for what it is prescribed:
_____
_____
_____

Describe any side effects you experience from the medications you are taking. _____
_____
Previous medications and their side effects, if any:
_____

Significant relationship status:
□Single □Engaged □Married □Separated □Divorced □Widowed □Committed Relationship

Educational / Occupational (Adults):
Highest Grade Completed: _____ College: _____ Graduate School: _____
Are you currently employed? □Yes □No Employer: _____ How long: _____
Like / Dislike / Secure: _____ Describe your commute: _____

Educational / Occupational (Teens / Children):
Current Grade: _____ School: _____ Resource: □LD □ED □501
Ever failed a grade? □Yes □No If so, which one & why? _____
Favorite class: _____ Worst class: _____ Do you skip? _____
Extracurricular activities: _____
Behavior problems at school: _____

Describe what brings you to therapy. What symptoms, feelings, thoughts prompted you to seek counseling?
_____
_____
_____
How long has this been occurring? _____

On the scale below please indicate the severity: **1 2 3 4 5 6 7 8 9 10**
mildly upsetting ← — — — — — → incapacitating

What would you like to accomplish in therapy? _____
_____
_____
_____
_____
_____

ALCOHOL AND OTHER DRUG USE:

Please tell me about your use of alcohol and other substances:	Never	Seldom	1 X / Mo.	2-3 Times / Mo.	Weekly	Daily
I drink 4+ drinks in a 24-hour time period.	☐	☐	☐	☐	☐	☐
I have missed work/school due to drinking.	☐	☐	☐	☐	☐	☐
After drinking, I have forgotten where I was or what I did.	☐	☐	☐	☐	☐	☐
I use other recreational drugs*.	☐	☐	☐	☐	☐	☐
I have missed work/school due to recreational drugs.*	☐	☐	☐	☐	☐	☐
After using recreational drugs*, I have forgotten where I was or what I did.	☐	☐	☐	☐	☐	☐

**RECREATIONAL DRUGS INCLUDE among others: marijuana; cocaine; ecstasy; heroin; meth as well as any prescription or over-the-counter drugs taken for recreational purposes.*

Previous Mental Health Treatment:
Please list any previous mental health providers (psychiatrists, therapists, hospitals, self-help groups, and / or residential treatment centers) along with the issues for which you were seen:
_____
_____
_____

FAMILY MENTAL HEALTH TREATMENT:

	If YES, please check the box for <u>all</u> applicable family members:								Successfully Treated?	
	No One	**Mother**	**Father**	**Brothers**	**Sisters**	**Cousins**	**Aunts/ Uncles**	**Grand-Parents**	**Yes**	**No**
Clinical Diagnosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety / Panic Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Post-traumatic Stress Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obsessive-Compulsive Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Borderline Personality Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Schizophrenia or Psychosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol or Other Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

HOME / FAMILY EXPERIENCES:

Did the following occur in your family / home environment?	**Yes**	**No**	**Not Sure**
Parents divorced or permanently separated	☐	☐	☐
Frequent, hostile arguing among family members	☐	☐	☐
Death of a parent or sibling	☐	☐	☐
Parent(s) or sibling(s) with a drinking or drug problem	☐	☐	☐
Family member with an eating problem	☐	☐	☐
Family member with a debilitating illness, injury, or disability	☐	☐	☐
Family member prosecuted for criminal activity	☐	☐	☐
Family member attempted / committed suicide	☐	☐	☐
Physical abuse in your family	☐	☐	☐
Sexual abuse in your family	☐	☐	☐

CURRENT & PREVIOUS SYMPTOMS / BEHAVIORS / EXPERIENCES:

NOW	PAST		NOW	PAST	
DISTRESSING SYMPTOMS			WORK/ACADEMIC CONCERNS		
☐	☐	Stress	☐	☐	Procrastination
☐	☐	Anxiety/ nervousness	☐	☐	Time Management
☐	☐	Panic attacks	☐	☐	Poor performance evaluations / grades
☐	☐	Perfectionism	☐	☐	Test, speech, or performance anxiety
☐	☐	Fearfulness / paranoia	☐	☐	Conflict with a colleague, boss, or professor
☐	☐	Obsessive thoughts	BODY IMAGE AND FOOD USE		
☐	☐	Compulsions/ rituals	☐	☐	Binge eating
☐	☐	Depression	☐	☐	Purging (vomiting)
☐	☐	Difficulty concentrating	☐	☐	Laxative use / abuse
☐	☐	Motivation problems	☐	☐	Diet pill use / abuse
☐	☐	Difficulty *falling* asleep	☐	☐	Restricting food intake
☐	☐	Difficulty *staying* asleep	☐	☐	Avoiding certain food(s)
☐	☐	Loss of appetite	☐	☐	Dieting
☐	☐	Excessive crying	☐	☐	Overeating
☐	☐	Irritability / anger / hostility	☐	☐	Excessive exercise
☐	☐	Mania (overly energized with unusual thoughts or behaviors)	ADDICTION / DEPENDENCE CONCERNS		
☐	☐	Suicidal feelings / thoughts	☐	☐	Smoking / tobacco use
☐	☐	Suicide attempt(s)	☐	☐	Excessive internet use
ROMANTIC RELATIONSHIP CONCERNS			☐	☐	Sexual addiction
☐	☐	Dating concerns	☐	☐	Alcohol addiction / dependence / overuse
☐	☐	Concerns about sex	☐	☐	Drug addiction / dependence / overuse
☐	☐	Conflict with partner / spouse	SOCIAL RELATIONSHIP CONCERNS		
☐	☐	Break-up / end of relationship	☐	☐	Difficulty making friends
GENDER/SEXUAL ORIENTATION CONCERNS			☐	☐	Loneliness
☐	☐	Gender identity or gender issues	☐	☐	Social Anxiety
☐	☐	Orientation questions	☐	☐	Conflict with friend(s)
☐	☐	Transgender issues	☐	☐	Bullying