

SOCIAL HISTORY

DATE:

Answer **ALL** if the following questions.

PERSONAL DATA

NAME: (Last, First, Middle Initial):

Social Security #:

Referred by:

AGE:

DATE OF BIRTH:

SEX:

EDUCATION:

Primary Language

RELIGION:

RACE:

MARITAL STATUS:

State of Birth:

PRESENT ADDRESS: (City & State)

Ethnicity:

ZIP CODE:

HOME PHONE:

WORK PHONE:

CELL PHONE:

PLACE OF EMPLOYMENT:

PRESENT HEALTH:

DATE OF MARRIAGE:

SPOUSE'S NAME AND DATE OF BIRTH:

AGE:

SOCIAL SECURITY:

PLACE OF EMPLOYMENT:

NUMBER OF CHILDREN: (Give ages and sex)

PERSON TO NOTIFY IN CASE OF EMERGENCY:

PRIOR MARRIAGES?

(If yes, give length of marriage & age of children)

YES

NO

LENGTH: _____ AGES OF CHILDREN: _____

PRIOR MARRIAGES OF SPOUSE

(If yes, give length of marriage & age of children)

YES

NO

LENGTH: _____ AGES OF CHILDREN: _____

FATHER'S AGE:

EDUCATION:

OCCUPATION:

PRESENT HEALTH:

STEPFATHER:

YES

NO

(If yes, what was your age at the time he became your stepfather)

PRESENT HEALTH:

MOTHER'S AGE:

EDUCATION:

Mother's Maiden

OCCUPATION:

PRESENT HEALTH:

Name

STEPMOTHER:

YES

NO

(If yes, what was your age at the time he became your stepmother)

PRESENT HEALTH:

LIST OF BROTHERS & SISTERS: (Give ages & indicate step or half siblings, when applicable)

MENTAL HEALTH TREATMENT HISTORY

PREVIOUS MENTAL HEALTH HISTORY:

PATIENT

FAMILY

NONE

HOW LONG HAS CURRENT PROBLEM EXISTED?

HOW DO YOU CONSIDER YOUR PROBLEM?

SEVERE

MODERATE

MINIMAL

HAVE YOU RECEIVED MENTAL HEALTH ASSISTANCE IN THE PAST?

YES

NO

If yes, with whom?

FAMILY PHYSICIAN & CLINIC:

ARE YOU PRESENTLY BEING TREATED BY ANOTHER DOCTOR OR THERAPIST?

YES

NO

IF YES, FOR WHAT CONDITION?

HAVE YOU EVER BEEN HOSPITALIZED FOR MENTAL HEALTH TREATMENT?

YES

NO

IF YES, WHERE & WHEN?

WHO WAS YOUR DOCTOR?

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? (Names & Dosages)

WORK HISTORY & PRESENT EMPLOYER:

LIST LEGAL PROBLEMS, IF ANY:

MENTAL HEALTH TREATMENT HISTORY (Continued)

WHAT BRINGS YOU TO SEEK MENTAL HEALTH TREATMENT AT THIS TIME? *(Explain briefly)*

HOW DO YOU THINK THIS TREATMENT MAY HELP YOU? *(Explain briefly)*

SPECIAL NEEDS: *(Wheelchair, sign language interpreter, etc.)*

FAMILY HISTORY

PLEASE TELL SOMETHING OF YOUR OWN BACKGROUND AND DEVELOPMENT, GIVING BIRTHPLACE, NATIONALITY, SIZE OF FAMILY, ECONOMIC CONDITION AND RELIGIOUS AFFILIATION. DESCRIBE ANY SIGNIFICANT FACTS ABOUT YOUR OWN PARENTS, INCLUDING OCCUPATION, EDUCATION, AND PERSONALITY TRAITS, HOW DID YOU GET ALONG TOGETHER AS A FAMILY? WERE THERE ANY SPECIAL PROBLEMS, SUCH AS DRINKING, SEPARATIONS, PHYSICAL, MENTAL, OR EMOTIONAL ILLNESSES? WHAT INFLUENCE HAVE YOUR PARENTS, RELATIVES, OR OTHER PERSONS HAD IN YOUR RAISING AND/OR YOUR CHILDRENS RAISING? IF YOUR PARENTS OR GRANDPARENTS ARE DECEASED, PLEASE GIVE DATE AND CAUSE OF DEATH.

CHECK THE FOLLOWING SYMPTOMS AND EXPLAIN UNDER REMARKS.

		Severity (1= low to 10= high)	Frequency
	1. Frequent severe headaches		
	2. Recurring dizziness or fainting spells		
	3. Unusual tastes, bad odors, strange visual images		
	4. Recurring tightness or spasm in neck or back muscles		
	5. Prolonged difficulty swallowing or catching breath		
	6. Recurring pain or pressure in chest		
	7. Palpitations or pounding of your heart		
	8. Recurring indigestion or stomach trouble		
	9. Trouble with bowels or bladder		
	10. Frequent numbness or tingling		
	11. Trouble remembering things		
	12. Trouble with alcohol or drugs		
	13. Difficulty sleeping at night or early morning awakening		
	14. Frequent or recurring nightmares		
	15. Recurring bedwetting or sleepwalking		

REMARKS (Explain any items checked above such as frequency of severity of symptoms)

		Severity (1= low to 10= high)	Frequency
	16. <u>Frequent or prolonged feelings of:</u>		
	Severe depression or sadness		
	Constant tiredness and lack of energy		
	Severe anxiety or nervousness		
	Unusual happiness or excessive energy		
	That you are about “to explode”		
	Extreme apathy or not caring what happens to you		
	17. <u>Frequent or troublesome thoughts that:</u>		
	Seem to recur no matter what you do		
	You might hurt yourself or someone else		
	Something terrible is wrong with you		
	People are watching you or are against you		
	Race through your head “out of control”		
	You are “bad” because of your past childhood		
	Suicide is an option		

