❑ Warrensburg
❑ Clinton
❑ Warsaw

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ADULT SOCIAL HISTORY

Please complete this form as thoroughly and accurately as you can. This information will be used by your therapist to help in your diagnosis and therapy, and will be kept CONFIDENTIAL. Give the completed form to the receptionist prior to seeing the therapist. If you are seen at home, give the completed form to the therapist no later than the second visit. IF YOU REQUIRE ASSISTANCE, PLEASE ASK THE RECEPTIONIST OR THERAPIST.

IDENTIFICATION

Your legal name: _____
FIRST MIDDLE LAST

Nickname: _____ Sex: _____ Age: _____

Date of birth: _____ Social Security #: _____
MONTH DAY YEAR

Home address: _____
street city state zip

Home phone #: _____ Work phone #: _____

Personal Physician: _____

Address: _____ Phone #: _____

Family or Specialty Physician: _____

Address: _____ Phone #: _____

In case of an emergency, whom should we contact? _____

Relationship: _____ Home Phone #: _____

Address: _____ Work Phone #: _____

PRESENTING PROBLEM AND REFERRAL INFORMATION

Have you had previous treatment here? _____ If yes, when? _____ With? _____

Are you currently in treatment elsewhere? _____ If yes, where and with whom? _____

Who referred you to our services? _____

Please describe briefly the reason(s) why you came to see us: _____

_____

_____

_____

_____

_____

Please answer the following questions regarding your medical history and briefly explain all questions marked Yes in the space provided at the end. (circle one per statement)

N=Never **S**=Sometimes (LESS THAN ONCE PER WEEK) **O**=Often (2-3 TIMES PER WEEK) **A**=Always (NEARLY EVERY DAY)

MOOD				
Feeling sad, depressed or despondent	N	S	O	A
Feeling tired, fatigued or lacking energy	N	S	O	A
Difficulty finding enjoyment or pleasure	N	S	O	A
Crying or feeling like crying	N	S	O	A
Feeling your situation is hopeless	N	S	O	A
Feeling worthless or useless to others	N	S	O	A
Losing interest in __ work or __ hobbies	N	S	O	A
Withdrawing or staying away from people	N	S	O	A
Thinking about dying or ending it all	N	S	O	A

COGNITIVE				
Having trouble concentrating	N	S	O	A
Finding it difficult to make decisions	N	S	O	A
Being forgetful or trouble with memory	N	S	O	A
Difficulty following instructions	N	S	O	A
Being confused or having trouble thinking	N	S	O	A
Trouble with thoughts racing	N	S	O	A
Thinking strange or odd thoughts	N	S	O	A
Having intruding or unwanted thoughts	N	S	O	A
Concerned that others are out to get you	N	S	O	A
Hearing voices inside your head	N	S	O	A

ALERTNESS				
Having trouble listening to others	N	S	O	A
Losing or misplacing items you need	N	S	O	A
Starting something but not finishing it	N	S	O	A
Acting before thinking what might result	N	S	O	A
Making careless mistakes, missing details	N	S	O	A
Trouble organizing your work or time	N	S	O	A
Getting bored easily or losing interest	N	S	O	A
Impatient or having trouble waiting	N	S	O	A
Interrupting others before they finish	N	S	O	A

ACTIVITY LEVEL				
Always needing to be doing something	N	S	O	A
Feeling restless or fidgety	N	S	O	A
Liking thrills or high-risk activities	N	S	O	A
Procrastinating or putting things off	N	S	O	A
Having many projects going at once	N	S	O	A
Shifting from activity to activity	N	S	O	A
Shaking, trembling or having tremors	N	S	O	A

ANXIETY				
Fretting or worrying about things	N	S	O	A
Feeling apprehensive or fearful in general	N	S	O	A
Being shy or easily embarrassed	N	S	O	A
Afraid of certain situations or things	N	S	O	A
Recurring worries, fears or actions	N	S	O	A
Avoiding social or performance situations	N	S	O	A
Recurring distressing memories or dreams	N	S	O	A

ANGER				
Feeling snappy or irritable with others	N	S	O	A
Losing your temper easily	N	S	O	A
Getting angry over small things	N	S	O	A
Arguing with family members or friends	N	S	O	A
Threatening or thinking of harm to others	N	S	O	A
Fighting, shoving or hitting others	N	S	O	A

PHYSICAL COMPLAINTS				
Difficulty falling asleep	N	S	O	A
Awakening in the middle of the night	N	S	O	A
Awakening too early before the normal time	N	S	O	A
Lose of appetite or not hungry	N	S	O	A
Increase in appetite or eating more	N	S	O	A
Having - stomach aches or - discomfort	N	S	O	A

CHEST				
Shortness of breath or trouble breathing	N	S	O	A
Tightness, like a band around chest	N	S	O	A
Choking, smothering or trouble swallowing	N	S	O	A
Chest pain or discomfort	N	S	O	A
Heart pounding or racing	N	S	O	A
Palpitations or heart skipping a beat	N	S	O	A

SENSATIONS				
Sweating excessively or feeling flushed	N	S	O	A
Numbness or tingling in hands or feet	N	S	O	A
Muscle tension or tightness	N	S	O	A
Feeling __weak or __faint	N	S	O	A
Feeling dizzy or light-headed	N	S	O	A
Chills or hot flashes	N	S	O	A

PERCEPTIONS				
Feelings of unreality	N	S	O	A
Feeling detached from or outside oneself	N	S	O	A
Fears of losing control or going crazy	N	S	O	A
Feeling as if skin is crawling	N	S	O	A
Jumpy or easily startled or frightened	N	S	O	A
Memory blackouts or gaps in memory	N	S	O	A

SENSES				
Oversensitive to light	N	S	O	A
Oversensitive to noise or sounds	N	S	O	A
Change in taste: __ heightened or __dulled	N	S	O	A
Change in smell: __heightened or __ dulled	N	S	O	A
Change in touch: __ more / __ less sensitive	N	S	O	A
Sensitivity to pain: __ more or __ less	N	S	O	A

BODY				
Significant weight __ gain or __ loss	N	S	O	A
Feeling too __ fat, __ thin / __ unattractive	N	S	O	A
Being clumsy or uncoordinated	N	S	O	A
Having little or no energy	N	S	O	A
Having too __ little or __ high sex drive	N	S	O	A
Frequent pain (where?) _____	N	S	O	A

OTHER

_____

_____

_____ N S O A

How long have you had these problems? _____

What have you tried to solve these problems? _____

_____

Outcomes? _____

Has anyone in your family had similaror other problems like these? __ Yes __ No

If Yes, Who? _____ What? _____

Outcome? _____

Who? _____ What? _____

Outcome? _____

Do you eat balanced meals? ___ Yes ___ No Three meals a day? ___ Yes ___ No Fast Foods?___ Yes ___ No
Describe your eating habits: _____
Are you under a physician's care for any condition or illness? ___ Yes ___ No If yes, please explain: _____

Please list any prescribed, over-the-counter or herbal medication you take:

Medication	Dosage	Times per day	Reason for taking

When did you last see your physician for an exam or checkup? _____ Dr.:_____
Significant illnesses, accidents or surgeries, or any hospitalizations:

Type of illness or problem	Age / Year	Reason & Outcome

MARITAL AND CURRENT FAMILY HISTORY

What is your current marital status? ___ Single ___ Married ___ Living as married ___ Separated ___ Divorced ___ Widowed
What is your spouce/partner's name? _____
How long married or living together? _____ Date Married: _____ Date living together: _____
Describe your partner _____
Were you previously married? ___ Yes ___ No If yes, how many times? _____
Any children, including current and previous marriages or relationships:

Name	Sex	Age	Living with	Health	Other Parent

Are there other people living within your home who are not related to you? ___ Yes ___ No.
If Yes, pleas give their name and reason they are in your home. _____
_____

FAMILY OF ORIGIN HISTORY

Please list the members of the family in which you grew up, and complete the information requested:
Were you adopted? ___ Yes ___ No If yes, what circumstances: _____
If yes, please provide information about your biological parents, if known. If your parents were divorced, widowed, please include Step- or adoptive parents.

Name	Relationship	Age	Occupation	Health

If your parents were separated or divorced, please give the dates and the reason: _____
_____

If your parents or siblings are no longer living, please give the date of their death, their age and the cause of death.

Have any of your parents, grandparents, aunts, uncles, siblings or cousins had any of the following?
If yes, who and which parent's family side?

___ Alzheimer's ___
___ Manic Depression ___
___ Psychosis ___
___ Nerve Disease ___
___ Muscle Disease ___
___ Lung Disease ___
___ Stroke ___
___ Diabetes ___
___ High Blood Pressure ___
___ Heart Disease ___
___ Cancer ___
___ Other (please explain) ___

___ Suicide ___
___ Anxiety ___
___ Eating Disorder ___
___ Anger Problems ___
___ Slow Learner ___
___ Autism/PDD ___
___ Hyperactive ___
___ Alcoholism ___
___ Drug Abuse ___
___ Delinquency ___
___ Criminal Behavior ___

Are you at risk or currently experiencing similar problems to those which your relatives had? __ Yes __ No
If yes, to whom? What? ___

ALCOHOL AND DRUG USE OR ABUSE

(Note: This information is confidential and cannot be revealed to others without your permission, unless you have been ordered by a court to have a substance abuse evaluation or treatment, or in certain other situations.)

Do you drink Alcoholic beverages? ___ Yes ___ No If yes, what kind: ___
How would you describe your alcohol use? ___ Social ___ Recreational ___ Infrequent ___ Occasional ___ Often
Has anyone in our family complained about your drinking? ___ Yes ___ No
Has your drinking caused problems for you recently or in the past? ___ Yes ___ No
If yes, ___ DWI ___ Family Conflict ___ Fights/Assault ___ Financial problems?
Please explain: ___
Have you in the past or recently used any illegal drugs or substances? ___ Yes ___ No If yes, what? ___
How would you describe your drug use? ___ Social ___ Recreational ___ Infrequent ___ Occasional ___ Frequent
Has your use of drugs caused any family or legal problems? ___ Yes ___ No If yes, what? ___

LEGAL / CRIMINAL HISTORY

As an adult, have you ever been arrested, cited or ticketed? ___ Yes ___ No
If yes, please explain ___
Are you or have you been ordered by the Court or a government entity to participate in counseling or an evaluation? __ No __Yes
If yes, please explain ___
Are you involved in any litigation, divorce, custody conflict, law suit. disability claim, workman's compensation, or injury claim?
___No ___ Yes If yes, please explain. ___
Did an attorney direct you to get an evaluation or counseling? ___ No ___ Yes If yes, please explain ___
For what purpose? ___
When younger, were you ever arrested or involved with the Juvenile Court? ___ No ___ Yes
If yes, please explain ___

EARLY DEVELOPMENT, CHILDHOOD AND EDUCATION

When younger, did you have any of the following illnesses or conditions?

___ Measles	___ Mumps	___ Chicken Pox	___ Small Pox	___ Ear Infections/Aches
___ Seizures	___ Polio	___ Bed-wetting	___ Nightmares	___ Frequent Sickness
___ Tantrums	___ Shyness	___ High Fever	___ Soiling	___ Frequent Stomachaches
___ Allergies	___ Cancer	___ Stuttering	___ Fighting	___ Hyperactivity
___ Sleep Problems	___ Heart Murmur	___ TB	___ Attention Problems	___ Delayed Speech
___ Accident Prone	___ Mononucleosis	___ Learning Problems	___ Eating Disorder	___ Head Banging
___ Abuse	___ Frequent Moves	___ Delinquency	___ Strep Throat	___ Skipping School

___ Other (please explain) ___
Place of your birth: ___
Were you raised by your parents ___ Yes ___ No If No, please explain ___
How was your mother's health before and when you were born? ___
About how old were you when you walked? ___ Said first word? ___
Spoke 2 or 3 work sentences? ___ Dressed self? ___ Rode a bicycle without training wheels? ___
Were weaned? ___ Were toilet trained? ___ Fed yourself? ___ If you don't know, answer with "?"
Were you ever a victim of verbal, physical or sexual abuse? ___No ___ Yes
If yes, please explain ___

Did you ever run away from home? ___ No ___ Yes If yes, please explain _____
Were you ever expelled or suspended from school? ___ No ___ Yes If yes, please explain _____
Most interesting subjects _____
Least interesting subjects _____ Why? _____
What sort of grades did you make? _____ How did you get along with teachers? _____ other students? _____
What clubs or sports were you in? _____
Age when you began school: _____ Please circle highest grade completed:

Elementary School	K 1 2 3 4 5 6	Where? _____	
Jr. & Sr. High	7 8 9 10 11 12 GED	Where? _____	Date graduated _____
Vocational School _____		Where? _____	Date graduated _____
College	1 2 3 4 5 6 7 8	Where? _____	Major _____ Degrees _____

WORK / EMPLOYMENT HISTORY

Please list your work history, beginning with the current or most recent.

Employer	Position	Dates employed	Reason for leaving
_____	_____	_____to_____	_____
_____	_____	_____to_____	_____
_____	_____	_____to_____	_____
_____	_____	_____to_____	_____
_____	_____	_____to_____	_____
_____	_____	_____to_____	_____

Were you ever fired or let go from work because of your behavior, attitude, missing work, being late, poor motivation or interest, personal problems, injuries or illness? ___ No ___ Yes If yes, please explained _____
Are you now or have you ever served in the Armed Forces? ___ No ___ Yes If yes, please answer the following questions:
Branch _____ From _____ to _____
If no longer in the military, type of discharge _____
Were you ever seen by a mental health or behavioral health provider while in the service? ___ No ___ Yes
If yes, pleas explain _____
Were you ever court-martialled? ___ No ___ Yes If yes, please explain _____

RECREATIONAL AND ACTIVITY HISTORY

How many hours per week do you spend in recreational activities? _____
What are your favorite recreational activities? _____
With whom do you like to spend your leisure time? _____
How many days per week do you exercise? _____ How many hours ? _____ What form(s)? _____
Recently has there been a significant increase or decrease in the amount of time that you spend in leisure activities? _____
If yes, please explain _____

SPIRITUAL / RELIGIOUS HISTORY

When younger, did you attend Synagogue, Temple, Mosque, Sunday School/Church? ___ No ___ Yes
If yes, how often? _____ Do you still attend? ___No ___ Yes What faith?: _____
Is your faith a source of strength to help with your present problems? ___ Yes ___ No
If not, does it cause ay problems? (e.g. guilt, pressure from members, lack of support, none locally, etc.)
_____
If yes, what support? _____

FRIENDSHIPS AND SOCIAL SUPPORT NETWORK

How many close or good friends do you have? _____ How many times per month do you keep contact? _____
What do you do with your friends? _____
How do your friends help? ___ Companionship ___ Recreation ___ Stress Relief ___ Advice ___ Blow Off Steam
___ Change of Routine ___ Sitter ___ Transportation ___ Other: _____
What do you consider your strengths? _____
What would you like to improve about yourself? _____
Please list the three things you most wish help with at this time:
1. _____
2. _____
3. _____
Date: _____ Person completing the form: _____
Reviewed by therapist: _____ Date: _____