

ADULT SOCIAL HISTORY

Name: _____ Today's Date: ___/___/___
 Sex: ___ Male ___ Female Age: _____ Birth Date: ___/___/___
 Primary Address: _____ City: _____ Zip: _____

FAMILY HISTORY

Marital status: _____ Spouse's name / Years married: _____ / _____
 Number of previous marriages: ___ None ___ One ___ Two ___ Three
 How would you describe your current marriage: _____
 Previous marriage(s): _____

List your biological children in birth order:			List all people living with you:		
Name	Age	Grade	Name	Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Marital status of biological or adoptive parents (Circle one):
 Never Married Married Separated Divorced Widowed

If separated, divorced, or widowed, how old were you when this occurred? _____
 How would you describe their relationship when you were a child? _____

GENETIC HISTORY

Please check any **biological** relatives with a history of the following concerns:

Academic difficulties	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
Attention deficits	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
Depression	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
Bipolar	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
Anxiety	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
OCD	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
Anger control problems	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin
Substance abuse	___ Mother	___ Father	___ Sibling	___ Aunt/Uncle	___ Grandparent	___ Cousin

PHYSICAL HEALTH

Primary Care Physician: _____ Phone: _____
 Psychiatrist: _____ Phone: _____
 Current health problems: _____
 Medications Prescribed: _____
 Have you ever suffered any head injuries? ___ No ___ Yes Specify: _____
 Do you have any eating problems? ___ No ___ Yes Specify: _____
 Have you lost or gained significant weight in the past 6 months? ___ No ___ Yes
 Do you have any sleeping problems? ___ No ___ Yes Specify: _____
 How many hours of sleep do you get per night? _____ Do you feel rested once awake? ___ No ___ Yes
 How often, and in what way, do you engage in sustained physical activity? _____
 How often do you consume alcohol? ___ Never/Rarely ___ Weekly ___ Daily
 On average, how many servings of alcohol do you consume in a single sitting? ___ Less than 2 ___ More than 2
 How often do you smoke? ___ Never/Rarely ___ Daily
 Do you currently, or have you in the past, used illegal drugs or abused prescription drugs? ___ No ___ Yes
 If yes, what substances and how frequently?: _____
 Have you ever participated in a drug or alcohol program or group (e.g., Alcoholics Anonymous)? ___ No ___ Yes
 Have you ever lived with someone who had a drug or alcohol dependency? ___ No ___ Yes Specify: _____

MENTAL HEALTH

Have you ever been diagnosed with a mental health disorder? ___ No ___ Yes Specify: _____

Have you ever had psychological testing? ___ No ___ Yes If yes, when: _____

Have you ever been hospitalized for emotional or behavioral concerns? ___ No ___ Yes
Specify: _____

Have you had prior counseling or psychotherapy? ___ No ___ Yes Specify: _____

Have you ever experienced an event that you would describe as traumatic? ___ No ___ Yes
Specify: _____

Have you ever experienced, specifically, any of the following?:
___ Neglect/Abandonment ___ Verbal/Emotional Abuse ___ Physical Abuse ___ Sexual Abuse

Are you currently experiencing suicidal thoughts? ___ No ___ Yes Specify: _____

Have you ever experienced suicidal thoughts in the past? ___ No ___ Yes Specify: _____

Have you ever attempted to harm yourself physically? ___ No ___ Yes Specify: _____

Please circle any of the following areas if they are of current concern for you:

- | | | | | | |
|------------|-------------|---------------|------------|--------------|-----------------|
| Parenting | Marriage | Legal Matters | Work | Finances | Extended Family |
| Depression | Worry | Fears | Anger | Irritability | Self-Esteem |
| Sexuality | Pornography | Addictions | Loneliness | Conflict | Focus/Attention |
| Appetite | Digestive | Sleep | Headaches | Low Energy | Other Health |

Thought that are: Obsessive Racing Negative Self-Harming Violent

MILITARY HISTORY

Have you ever served in the military service? ___ No ___ Yes Which branch? _____
Age at enlistment: _____ Did you ever serve in combat? ___ No ___ Yes

LEGAL HISTORY

Do you have any legal action now pending? ___ No ___ Yes Specify: _____

Do you have any history of incarcerations, probations and/or parole? ___ No ___ Yes
Specify: _____

SPIRITUAL HISTORY

Although not required, the following questions would contribute to your therapist's understanding of you as a spiritual person. It is not our intent to impose our doctrinal perspective but to acknowledge that counseling is not value-free and to be sensitive to your beliefs. Feel free to discuss any questions or concerns you may have with your therapist

1. Are spiritual issues or resources important to you in your treatment? If so, briefly describe: _____

2. What, if any, spiritual practices does your family engage in? _____

3. How would you describe your relationship with God? _____

_____ Religious Affiliation, if any: _____