



## SOCIAL HISTORY QUESTIONNAIRE—ADULT FORM

This form is designed to provide your therapist with an overview of your experiences and history to assist with your treatment. All information on this form is completely confidential.

**Please fill out the form as completely as possible, giving details. If a question does not apply to you, please indicate by writing N/A on the line provided.**

Date form completed: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(Street) (City) (Zip)

Cell Ph: \_\_\_\_\_ Alternate Ph: \_\_\_\_\_

Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

List all members who are presently living in your household:

Name	Age	Relationship

### MAIN CONCERNS

Describe present problem for which you are seeking treatment (PLEASE GIVE DETAILS)

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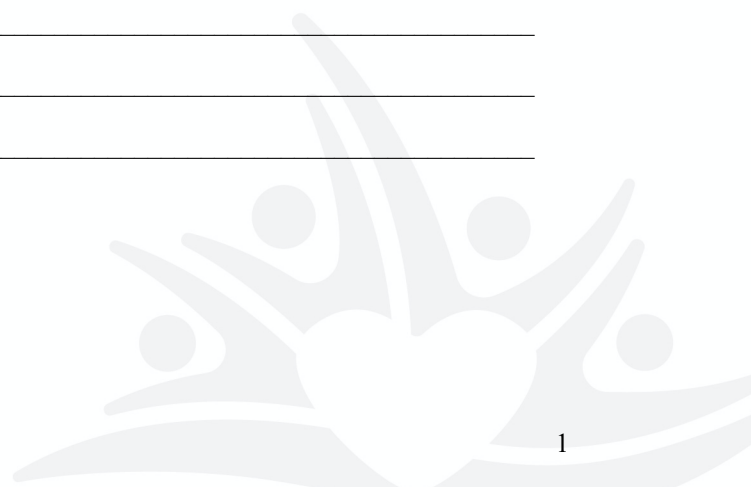
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# NEW OBJECTIVES

Psychology, Counseling & Neurofeedback Center

When did the problem start or when did you first notice it: \_\_\_\_\_

What have you done to try to solve the problem: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What do you believe is the main cause of the problem: \_\_\_\_\_

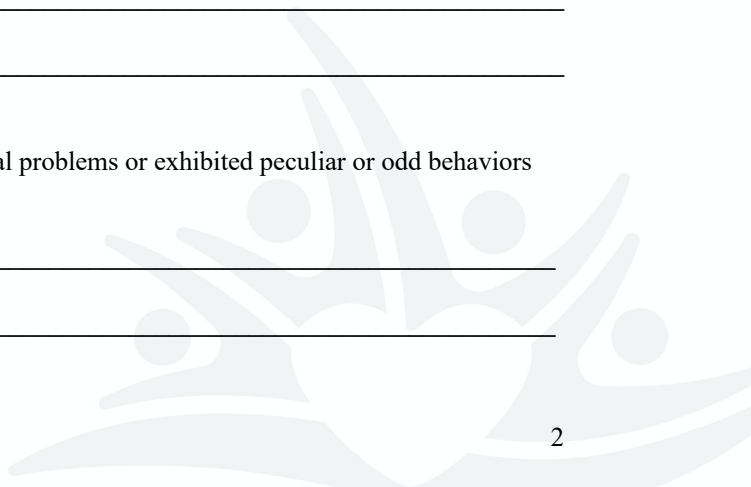
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## FAMILY HISTORY

	Name	Age	Education	Marital Status	Date of Death (if app)
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Step-parents	_____	_____	_____	_____	_____
Sibling(s)	_____	_____	_____	_____	_____
Ex-spouse(s)	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____

Have **ANY** family members been treated for mental or emotional problems or exhibited peculiar or odd behaviors (include immediate or extended family)? If yes, **EXPLAIN**.

\_\_\_\_\_  
\_\_\_\_\_





# NEW OBJECTIVES

Psychology, Counseling & Neurofeedback Center

Have you or any family members ever attempted suicide? \_\_\_\_\_ Committed suicide? \_\_\_\_\_

Name	Relationship	How	When

Are your parents:  
Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Both Deceased \_\_\_\_\_

If divorced, how old were you at the time of the divorce? \_\_\_\_\_

If one or both parents are deceased, how old were you when the death(s) occurred? \_\_\_\_\_

Describe your childhood (please be detailed) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

From your recollections as a child:  
Describe your mother and how you felt about her \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe your father and how you felt about him \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe your stepparents and how you felt about them \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe your siblings and how you felt about them \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





# NEW OBJECTIVES

Psychology, Counseling & Neurofeedback Center

## EDUCATIONAL HISTORY

As a child/adolescent:

Your average grades \_\_\_\_\_ Were you in any special classes \_\_\_\_\_

How did you feel about school \_\_\_\_\_

\_\_\_\_\_

Describe any problems in school that you experienced \_\_\_\_\_

\_\_\_\_\_

What is the highest grade you completed or degree you obtained \_\_\_\_\_

## LEGAL PROBLEMS

Have you ever had legal problems? If yes, explain. \_\_\_\_\_

\_\_\_\_\_

Are you having any legal difficulties now? (trial pending, lawsuits, custody battles, etc) If yes, explain.

\_\_\_\_\_

\_\_\_\_\_

## WORK HISTORY

Present employment (i.e. where, how long, job description) \_\_\_\_\_

\_\_\_\_\_

Describe briefly your previous employment history (i.e. approx. # of jobs in past 10 years, types of jobs, etc)

\_\_\_\_\_

\_\_\_\_\_

## DEVELOPMENTAL, MEDICAL AND PSYCHIATRIC HISTORY

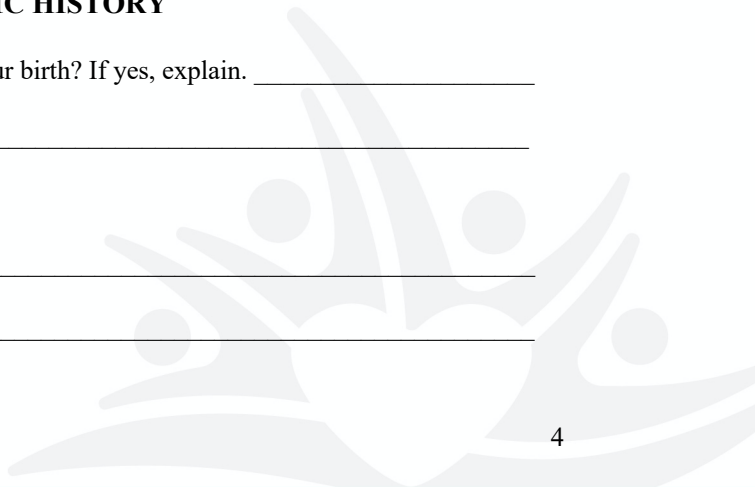
Were there any pregnancy complications or difficulties with your birth? If yes, explain. \_\_\_\_\_

\_\_\_\_\_

List **all** medical illnesses or conditions:

As a child: \_\_\_\_\_

As an adult: \_\_\_\_\_





# NEW OBJECTIVES

Psychology, Counseling & Neurofeedback Center

Have you ever had a head injury? If yes, explain. \_\_\_\_\_

List current medications you are taking:

Name	Reason	Dose	Prescribing Physician	Starting Date

Do you have any allergies? If yes, please list: \_\_\_\_\_

Do you have any physical disabilities or limitations? If yes, explain. \_\_\_\_\_

Have you ever been in therapy before?

When	Problem/Reason	Therapist's Name

Have you ever been hospitalized in a psychiatric unit?

When	Problem/Reason	Hospital Name

## SUBSTANCE USE HISTORY

Are you presently using street drugs? If yes, which ones, **how much and how often?** \_\_\_\_\_

Are you presently using alcohol? If yes, **how much and how often?** \_\_\_\_\_

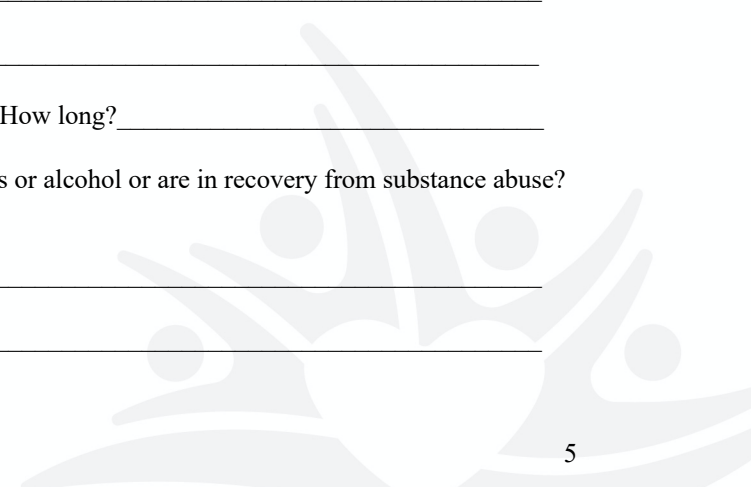
Are you now abusing drugs/alcohol? \_\_\_\_\_

Have you abused drugs/alcohol in the past? \_\_\_\_\_

Are you presently in recovery? \_\_\_\_\_ How long? \_\_\_\_\_

Are any family members addicted to or excessively using drugs or alcohol or are in recovery from substance abuse? If yes, explain.

\_\_\_\_\_  
\_\_\_\_\_





# NEW OBJECTIVES

Psychology, Counseling & Neurofeedback Center

Have you, presently or in the past, suffered from an eating disorder (i.e. Anorexia, Bulimia)? If yes, please explain.

\_\_\_\_\_

## SOCIAL HISTORY

List any **previous or present** marriages or current significant relationships:

Name of Spouse/Significant Other

Date of Marriage

Date of Divorce (if applicable)

\_\_\_\_\_

\_\_\_\_\_

If presently married or in a significant relationship, describe quality of relationship and any significant past or present difficulties:

\_\_\_\_\_

\_\_\_\_\_

Describe social life and activities (i.e. # of friends, hobbies, support systems, dating, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you experienced any of the following:

	Your age at the time	By whom
Death of a significant person	_____	_____
Physical abuse	_____	_____
Sexual abuse	_____	_____
Emotional abuse	_____	_____

Describe your goals for therapy (e.g. what do you hope to achieve from treatment): \_\_\_\_\_

\_\_\_\_\_

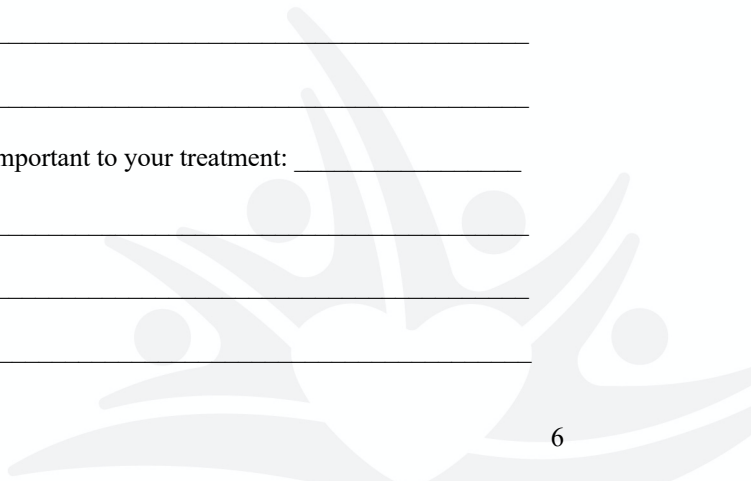
\_\_\_\_\_

Describe anything else that you think needs to be stated that is important to your treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who referred you to this office? \_\_\_\_\_





## Depression Checklist

Name: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Instructions:</b> Put a check mark to indicate how much you have experienced each symptom during the past week. Please answer all 25 items.		<b>0= Not at All</b>	<b>1= Somewhat</b>	<b>2= Moderately</b>	<b>3= A Lot</b>	<b>4= Extremely</b>
<b>Thoughts and Feelings</b>						
1	Feeling sad or down in the dumps					
2	Feeling unhappy or blue					
3	Crying spells or tearful					
4	Feeling discouraged					
5	Feeling hopeless					
6	Low self-esteem					
7	Feeling worthless or inadequate					
8	Guilt or shame					
9	Criticizing yourself or blaming others					
10	Difficulty making decisions					
<b>Activities and Personal Relationships</b>						
11	Loss of interest in family, friends, or colleagues					
12	Loneliness					
13	Spending less time with family or friends					
14	Loss of motivation					
15	Loss of interest in work or other activities					
16	Avoiding work or other activities					
17	Loss of pleasure or satisfaction in life					
<b>Physical Symptoms</b>						
18	Feeling tired					
19	Difficulty sleeping or sleeping too much					
20	Decreased or increased appetite					
21	Loss of interest in sex					
22	Worrying about your health					
<b>Suicidal Urges</b>						
23	Do you have any suicidal thoughts?					
24	Would you like to end your life?					
25	Do you have a plan for harming yourself?					



## Anxiety Inventory (1)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructions: The following is list of symptoms that people sometimes have associated with anxiety. Put a check mark in the space to the right that best describes how that symptom or problem has bothered you during this past week.	Symptoms List	0= Not at All	1= Somewhat	2= Moderately	3= A Lot

### Category I: Anxious Feelings

1.	Anxiety, Nervousness, Worry, and Fear				
2.	Feeling that things around you are strange, unreal, or foggy				
3.	Feeling detached from all or part of your body				
4.	Sudden unexpected panic spells				
5.	Apprehension or sense of impending doom				
6.	Feeling tense, stressed, "uptight", or on edge				

### Category II: Anxious Thoughts

7.	Difficulty concentrating				
8.	Racing thoughts or your mind jumps from one thing to the next				
9.	Frightening fantasies or daydreams				
10.	Feeling that you are on verge of losing control				
11.	Fears of cracking up or going crazy				
12.	Fears of fainting or passing out				
13.	Fears of physical illness or heart attacks or dying				
14.	Concerns about looking foolish or inadequate in front of others				
15.	Fears of being alone, isolated, or abandoned				
16.	Fears of criticism or disapproval				
17.	Fears that something terrible is about to happen				



## Anxiety Inventory (2)

### Symptoms List

#### Category III: Physical Symptoms

		0=Not at All	1=Somewhat	2=Moderately	3= A Lot
18.	Skipping or racing or pounding of the heart				
19.	Pain, pressure, or tightness in the chest				
20.	Tingling or numbness in the toes or fingers				
21.	Butterflies or discomfort in the stomach				
22.	Constipation or diarrhea				
23.	Restless or jumpiness				
24.	Tight, tense muscles				
25.	Sweating not brought on by heat				
26.	A lump in the throat				
27.	Trembling or shaking				
28.	Rubbery or "jelly" legs				
29.	Feeling dizzy, lightheaded, or off balance				
30.	Choking or smothering sensations or difficulty breathing				
31.	Headaches or pains in the neck or back				
32.	Hot flashes or cold chills				
33.	Feeling tired, weak, or easily exhausted				

