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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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:_____

_____

_____

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**.

_____

_____

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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_____

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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: _____

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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.

_____

_____

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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? _____

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Depression Checklist

Name: _____ Date: _____

Instructions: Put a check mark to indicate how much you have experienced each symptom during the past week. Please answer all 25 items.		**0= Not at All**	**1= Somewhat**	**2= Moderately**	**3= A Lot**	**4= Extremely**
Thoughts and Feelings						
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					
Activities and Personal Relationships						
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					
Physical Symptoms						
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					
Suicidal Urges						
23	Do you have any suicidal thoughts?					
24	Would you like to end your life?					
25	Do you have a plan for harming yourself?					

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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				

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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				

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