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)

Home Ph:_____ Cell Ph:_____ Wrk 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)

_____

_____

_____

_____

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**.

_____

_____

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:_____

_____

_____

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: _____

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.

_____

_____

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? _____

CLIENT INFORMATION

CLIENT NAME**:** _____

ADDRESS**:** _____
STREET

_____
CITY **STATE** **ZIP**

HOME PH:_____ CELL PH:_____ WRK PH:_____

MALE ( ) FEMALE ( ) S.S.#**:**_____
(if minor, Mom & Dad's #)

AGE:_____ DATE OF BIRTH**:**_____

MARITAL STATUS: S_____ M_____ D_____ W_____ SEPARATED_____

EMPLOYER: _____
(if minor, parent's employers)

OCCUPATION:_____

NEXT OF KIN:_____ RELATIONSHIP:_____ PHONE:_____

Who may we thank for referring you to this office?

_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO PROCESS ANY INSURANCE FORM OR TO OBTAIN AUTHORIZATION FOR SERVICES.

SIGNATURE:_____ DATE:_____

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize New Objectives Psychology, Counseling & Neurofeedback Center, Inc. and its associates to administer an evaluation and/or therapy services.

I realize at the initial evaluation the nature, purpose, and course of my treatment will be discussed. I further understand that this consent can be revoked orally or in writing prior to or during the treatment period.

I have read and fully understand the above Consent For Treatment. No guarantee or assurance has been made to me as to the results that may be obtained.

_____ _____

Client's Name (please print) Date of Birth

_____ _____

Client's Signature (**or parent/guardian, if client is a minor**) Today's Date

OFFICE FEE AND INSURANCE POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are happy to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our policy.

Billing of Insurance/Assignment of Benefits/Payments
If we are a provider for your insurance company, we will file your claim for you. You will be responsible for any deductible, co-pays and any denied claims. If we are not a provider for your insurance, we will provide you with the necessary documentation you will need to file your claim with your insurance company.

Insurance benefits vary among plans. We will verify your insurance information for you, but insurance companies will NOT guarantee to us that this information is accurate until the claim has been submitted for review. Also, please know that, over time, your insurance plan may change your benefits. They do not notify us of these changes so please inform us if there are any changes to your plan.

If after receiving payment from your insurance company, there is a balance due, we will apply that balance to your credit card given below. This may include a co-pay, deductible, claim denial or a recovery of funds from your insurance company.

Missed Appointment Policy
A *significant* amount of time is blocked out of the therapist's schedule for each session. When appointments are not cancelled in advance, it prevents us from being able to offer that appointment time to others. Therefore, a fee of $25.00 is charged for each missed session NOT cancelled by the business day PRIOR to the appointment (if you have two scheduled sessions on the same day, the charge will be $50.00).

Please Note: *If 3 missed appointment occur within a 12-month period, your account will be charged for any further missed appointments at the regular session rate.*

Credit Card Authorization: Permission is granted to charge my card for any remaining balance after insurance has paid their portion that remains due on the account.

MC / Visa / Discover # _____

Exp_____ Security Code on Back_____ Billing Address Zip Code_____

Name on Card_____

Cardholder's Signature_____ Today's Date_____

I have read and understand the office fee policies and assign insurance benefits to New Objectives Psychology, Counseling and Neurofeedback Center.

_____ _____
Patient Name Patient Signature (parent signature if minor)

LIMITS OF CONFIDENTIALITY

Although confidentiality and privileged communication remain rights of all clients of psychologists according to state law, some courts have held that if an individual is at risk of harming another human being, or themselves, it is the therapist's duty to warn the person or family of the client, other responsible party, or the authorities (e.g. police) of risk in order to prevent harm to self or others.

The therapist will not, if at all possible, inform such parties without first sharing that intention with the client. Every effort will be made to resolve the issue before such a breach of confidentiality takes place. It is also the legal responsibility of the therapist to report any known or suspected cases of neglect or abuse of minors or the elderly.

I have read the above and understand the legal responsibility and agree that New Objectives Psychology, Counseling and Neurofeedback Center, Inc. and its associates to make such decisions to disclose information when necessary.

_____ _____

Client's Name Date of Birth

_____ _____

Client's Signature (**or parent/Guardian, if client is a minor**) Today's Date