# 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? _____

NEW OBJECTIVES
Psychology, Counseling & Neurofeedback Center

# 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? | | | | | |

# 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.**<br><br>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<br>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 | | | | |