**Adult Social History**

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| **Client Name** (First, MI, Last)Click here to enter text. | **Today’s Date**Click here to enter a date. |
| **Presenting Problem** |
| What are the 2-3 primary reasons you are seeking counseling/therapy? |
| How long ago did you begin to be troubled by this problem?Click here to enter text. |
| List three (3) goals you would like to accomplish by attending counseling:1.2.3. |
| Is this the first time you’ve seen a therapist/counselor for these issues? Click here to enter text.If you have been in counseling before, please explain how previous counseling helped and/or didn’t help you with these issues.Click here to enter text. |
| **Symptom Checklist**Check All Current Problems |
| [ ] **Nutritional/Eating Pattern Changes/Disorders** |
|  | As evidenced by:[ ]  Self-induced Vomiting[ ]  Binge Eating[ ]  Use of Laxatives | [ ]  Increase in Appetite[ ]  Decrease in Appetite[ ]  Excessive Exercising | [ ]  Weight Gain[ ]  Weight Loss[ ]  None |
| [ ] **Pain Management** |
|  | As evidenced by:[ ]  Pain Interferes with Activities | [ ]  None |  |
| [ ] **Depressed Mood/Sad** |
|  | As evidenced by:[ ]  Loss of Interest in Activities[ ]  Empty Feeling[ ]  Fatigue/Loss of Energy[ ]  Thoughts of Harming Yourself | [ ]  Hopelessness[ ]  Worthlessness[ ]  Trouble Concentrating[ ]  None | [ ]  Indecisiveness[ ]  Recurrent Thoughts of Death[ ]  Feeling Sad or Depressed |
| [ ] **Grief Issues** |
|  | As evidenced by:[ ]  Loss of Loved One in Past Year | [ ]  Other Loss (Describe)Click here to enter text. | [ ]  None |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Today’s Date**Click here to enter a date. |
| [ ] **Anxiety** |
|  | As evidenced by: [ ]  Excessive Worry [ ]  Restlessness [ ]  Obsessions [ ]  Muscle Tension [ ]  None |  [ ]  Irritability [ ]  Compulsions [ ]  Difficulty Breathing [ ]  Pounding Heart | [ ]  Excessive Checking[ ]  Strong Fears[ ]  Shaking[ ]  Excessive Hand washing |
| [ ] **Traumatic Stress** |
|  | As evidenced by:[ ]  Recurrent/Intrusive/Distressing Thoughts/Images[ ]  Recurrent Dreams/Nightmares | [ ]  Startles Easily[ ]  Exposure to Traumatic Event | [ ]  None |
| [ ] **Anger/Aggression** |
|  | As evidenced by:[ ]  Threatens/Intimidates Others[ ]  Initiates Fights | [ ]  Physically Hurts People[ ]  Physically Hurts Animals | [ ]  Use of Weapons[ ]  None |
| [ ] **Oppositional Behaviors** |
|  | As evidenced by:[ ] Loses Temper[ ]  Argues[ ]  Deliberately Annoys Others | [ ]  Blames Others[ ]  Easily Annoyed[ ]  Angry and Resentful | [ ]  Spiteful/Vindictive[ ]  None |
| [ ] **Inattention** |
|  | As evidenced by:[ ]  Difficulty Sustaining Attention[ ]  Trouble Finishing Things | [ ]  Disorganized[ ]  Easily Distracted | [ ]  Forgetful[ ]  None |
| [ ] **Impulsivity** |
|  | As evidenced by:[ ]  Difficulty Resisting Impulses[ ]  None | [ ]  Trouble Waiting for Turn | [ ]  Frequently Interrupts |
| **Disturbed Reality Contact** |
|  | As evidenced by:[ ]  Hears Voices Others Don’t Hear | [ ]  Seeing Things Others Don’t See | [ ]  None |
| [ ] **Mood Swings/Hyperactivity** |
|  | As evidenced by:[ ]  Excessive Movement[ ]  Decreased Need for Sleep[ ]  None | [ ]  Excessive Talking[ ]  Irritability | [ ]  Rapid or Extreme Changes in Mood[ ]  Inflated Self-Esteem |
| [ ] **Addictive Behaviors** |
|  | As evidenced by:[ ]  Gambling[ ]  Pornography | [ ]  Internet[ ]  None | [ ]  Shopping |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Today’s Date**Click here to enter a date. |
| [ ] **Sleep Problems** |
|  | As evidenced by:[ ]  Difficulty Falling or Staying Asleep[ ]  Excessive Sleepiness | [ ]  Sleepwalking[ ]  None | [ ]  Frequent Nightmares |
| [ ] **Stressors**Click here to enter text. |
| [ ]  **Other**Click here to enter text. |
| **Living Situation** |
| **My Home**[ ]  Rent [ ]  Own | **\*\*Residential Care/Treatment Facility**[ ]  Hospital [ ]  Temporary Housing [ ]  Residential Care [ ]  Nursing Home |
| **\*\*Other** [ ]  Friend’s Home [ ]  Relative’s/Guardian’s Home [ ]  Foster Care Home [ ] Respite Care [ ]  Homeless Living with Friend [ ]  Homeless in Shelter/No Residence [ ]  Jail/Prison [ ]  Other: Click here to enter text. |
| **\*\*Identify Facility or Person’s Name**Click here to enter text. |
| **Primary Household** |
| Household Member Names | Relationship To Client | Age | Quality of Relationship (Staff Use Only) |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
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| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
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| Significant Family Members/Others not Listed Above | Relationship To Client | Age | Quality of Relationship (Staff Use Only) |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
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| **Client Name** (First, MI, Last)Click here to enter text. | **Today’s Date**Click here to enter a date. |
| **Education, Employment and Military Information** |
| **Education History** (check all that apply) [ ]  GED [ ]  HS Graduate [ ]  College | **Highest Grade Completed**Click here to enter text. | **Vocational Year Completed**Click here to enter text. |
| **College** No of years, quarters, or semesters Degree/Major Click here to enter text. Other Degrees Completed: Click here to enter text. |
| **History of Learning Difficulties** (including performance/behavioral problems due to AOD use) [ ] None reported [ ] Learning Disability Type: Click here to enter text. [ ] Mental Retardation: Click here to enter text. [ ] Special School Placement: Click here to enter text. [ ] Other: Click here to enter text. |
| **Barriers to Learning** [ ] None reported [ ] Inability to Read or Write Other: [ ]  Click here to enter text. |
| **Special Communication Needs** [ ] None reported [ ] TDD/TTY Device [ ] Sign Language Interpreter [ ] Assistive Listening Device(s) [ ] Language Interpreter Services Needed/Other Spoken Language: Click here to enter text. [ ] Other: Click here to enter text. |
| **Employment** (check all that apply) |
|  [ ] Full Time (35 hrs. or more per week) [ ] Part Time (less than 35 hrs. per week) [ ] Non-Competitive [ ] Unemployed – date last worked: Click here to enter text. |
| **Not in Labor Force** [ ] Disabled [ ] Retired [ ] Homemaker [ ] Student [ ] Living in Institution [ ] Other: Click here to enter text. |
| **If employed, name of employer and job title**Employer: Click here to enter text. Job Title: Click here to enter text. |
| **Job Performance History** |
| **Number of Jobs in Last 5 Years**Click here to enter text. | **Comments** (include performance/behavioral problems due to alcohol or drug use)Click here to enter text. |
| **Attendance** [ ] Above Average [ ] Normal [ ] Tardiness [ ] Absenteeism |
| **Performance** [ ] Exemplary [ ] Good [ ] Average [ ] Below Average |
| **Employment Interests/Skills** [ ] No [ ] Yes Are you satisfied with your job? [ ] No [ ] Yes (If not currently employed) Do you want to work? [ ] No [ ] Yes Are you experiencing financial problems? [ ] No [ ] Yes Are you concerned that employment will affect your benefits? |
| **Comments on Past or Current Employment/Education Skills/Interests** (include information relating to past or current employment/education skills and interestsClick here to enter text. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Today’s Date**Click here to enter a date. |
| **Military History** [ ] No [ ] Yes If yes, describe branch of service, any pertinent duties, and any trauma experienced during service, as applicableClick here to enter text. |
| **Type of Discharge** (if other than General/Honorable)Click here to enter text. |
| **Legal History** |
| **Legal Guardian/Custodian – Name, Address and Phone Number**   [ ] None Reported Name:Click here to enter text. Address:Click here to enter text. Phone: Click here to enter text. |
| **Current Legal Status** [ ] None Reported [ ] On Probation [ ] Detention [ ] On Parole [ ] AoD Related Legal Problems [ ] Conditional Release [ ] Outpatient Commitment [ ] Awaiting Charges [ ] Court Ordered to Treatment [ ] Others: Click here to enter text. |
| **History of Legal Charges**  [ ] None Reported | Juvenile: [ ] No [ ] Yes If yes: [ ] Status Offense (e.g., Unruly) [ ] DelinquencyAdult [ ] No [ ] Yes If yes: [ ] Misdemeanor [ ] Felony |
| **List and Date of Most Recent Legal Charges**Click here to enter text. |
| **Convictions** [ ] None Reported Click here to enter text. |
| **Incarcerations** [ ] None ReportedClick here to enter text. | **Name and Phone No. of Probation/Parole Officer** (if applicable) Click here to enter text. |
| **Civil Proceedings** [ ] None ReportedClick here to enter text. | **Domestic Relations Court Problems** (i.e., custody, protective services, restraining order)Click here to enter text. |
| **Juvenile Court Involvement (**related to child abuse, neglect, or dependency)Current: [ ] No [ ] Yes Comment: Click here to enter text.Past: [ ] No [ ] Yes Comment: Click here to enter text. |
| **Children’s Support Enforcement Orders** [ ] None ReportedClick here to enter text. |
| **Child Protective Services Involvement with Family** [ ] None ReportedClick here to enter text. |
| **Name of Children’s Protective Services Caseworker(s) Assigned to Family** (if applicable) [ ] None ReportedClick here to enter text. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Today’s Date**Click here to enter a date. |
| **Adult Health History Questionnaire**This form should be completed as fully as possible by client, but reviewed by medical or clinical staff |
| Have you had any of the following health problems? |
|  | Now | Past | Never | What Treatment Was Received and Date(s) |
| Anemia |  [ ]  |[ ]   [ ]  | Click here to enter text. |
| Arthritis |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Asthma |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Bleeding Disorder |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Blood Pressure (high or low) |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Bone/Joint Problems |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Cancer |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Cirrhosis/Liver Disease |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Diabetes |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Epilepsy/Seizures |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Eye Disease/Blindness |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Fibromyalgia/Muscle Pain |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Glaucoma |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Headaches |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Head Injury/Brain Tumor |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Hearing Problems/Deafness |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Heart Disease |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Hepatitis/Jaundice |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Kidney Disease |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Lung Disease |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Menstrual Pain |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Oral Health/Dental |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Stomach/Bowel Problems |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Stroke |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Thyroid |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Tuberculosis |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| AIDS/HIV |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Sexually Transmitted Disease |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Learning Problems |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Speech Problems |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Anxiety |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Bipolar Disorder |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Depression |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Eating Disorder |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Hyperactivity/ADD |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Schizophrenia |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Sexual Problems |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Sleep Disorder |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Suicide Attempts/Thoughts |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Other: Click here to enter text. |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| Other: Click here to enter text. |  [ ]  |  [ ]  |  [ ]  | Click here to enter text. |
| **Please note family history of any of the above conditions and client’s relationship to that family member**Click here to enter text. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Today’s Date**Click here to enter a date. |
| **Current Medication Information** (medical and psychiatric prescription/OTC/herbal) |
|  [ ] None Reported |
| **Medication** | **Rationale** | **Dosage/Route/Frequency** | **Staff Use Only: Compliance** |
|  |  |  | Yes | No | Partial | Unk |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| **Primary Care Physician** (name, phone no., and address)Click here to enter text. | **Date of Last Physical Exam**Click here to enter text. |
| **Other Prescribing Physician(s)** (name, phone no., and address)Click here to enter text. |
| **Past Psychiatric Medications** |
|  [ ] None Reported |
| **Past Psychiatric Medications** | **Reason for Stopping** |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| **Have you had medical hospitalization/surgical procedures in the last 3 years?** [ ] No [ ] Yes If yes, complete information below |
| **Hospital** | **City** | **Date** | **Reason** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Allergies/Drug Sensitivities** [ ] None [ ] Food (specify) Click here to enter text. [ ] Medicine (specify) Click here to enter text. [ ] Other (specify) Click here to enter text. |
| **Pregnancy History** [ ] Not Pertinent |
| **Currently Pregnant?** (If yes, expected delivery date) [ ] No [ ] Yes Expected Delivery Date Click here to enter a date. | **Receiving Prenatal Healthcare?** (If yes, indicate provider) [ ] No [ ] Yes Provider Click here to enter text. |
| **Currently Breastfeeding?** [ ] No [ ] Yes |
| **Last Menstrual Period Date**Click here to enter a date. | **Any Significant Pregnancy History?** (if yes, explain) [ ] No [ ] Yes Click here to enter text. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Today’s Date**Click here to enter a date. |
| **Medical Information** |
| **Last Physical Examination**By Whom:Click here to enter text. Date: Click here to enter text. Phone No.(if known): Click here to enter text. |
| **Indicate how many times in the past 12 months you have used these medical services:** Hospital admissions Emergency room visits Regular visits to doctor Regular visits to dentist |
| **Have you had any of the following symptoms in the past 60 days?** (please check all that apply) |
|  [ ] Ankle Swelling |  [ ] Diarrhea |  [ ] Nervousness |  [ ] Tingling in Arms and/or Legs |
|  [ ] Bed wetting |  [ ] Dizziness |  [ ] Nosebleeds |  [ ] Tremor |
|  [ ] Blood in Stool |  [ ] Falling |  [ ] Numbness |  [ ] Urination Difficulty |
|  [ ] Breathing Difficulty |  [ ] Gait Unsteadiness |  [ ] Panic Attacks |  [ ] Vaginal Discharge |
|  [ ] Chest Pain |  [ ] Hair Change |  [ ] Penile Discharge |  [ ] Vision Changes |
|  [ ] Confusion |  [ ] Hearing Loss |  [ ] Pulse Irregularity |  [ ] Vomiting |
|  [ ] Consciousness Loss |  [ ] Lightheadedness |  [ ] Seizures |  [ ] Other: Click here to enter text. |
|  [ ] Constipation |  [ ] Memory Problems |  [ ] Shakiness |  |
|  [ ] Coughing |  [ ] Mole/Wart Changes |  [ ] Sleep Problems |  |
|  [ ] Cramps |  [ ] Muscle Weakness |  [ ] Sweats (night) |  |
| **Immunizations – Have you had or been immunized for the following diseases?** (please check all that apply) |
|  [ ] Chicken Pox [ ] Mumps |  [ ] Diphtheria [ ] Polio |  [ ] German Measles [ ] Small Pox |  [ ] Hepatitis B [ ] Tetanus |  [ ] Measles [ ] Other: Click here to enter text. |
| **Immunizations Within the Past Year**Click here to enter text. |
| **Height**Click here to enter text. | **Has client’s weight changed in the past year?** [ ] No [ ] Yes If yes, by how much (+ or -):  |
| **Weight**Click here to enter text. |
| **Nutritional Screening** |
| **No Problem** [ ]  | **Eating** [ ] More [ ] Less [ ] Not Eating | **Drinking** [ ] More [ ] Less [ ] Takes Liquids Only | **Appetite** [ ] Increased [ ] Decreased |
|   [ ] Nausea [ ] Vomiting [ ] Trouble Chewing or Swallowing |
| **Special Diet**Click here to enter text. | **Other**Click here to enter text. |
| **Pain Screening** |
| **Does pain currently interfere with your activities?** (if yes, how much does it interfere with these activities [please check]) [ ] No [ ] Yes [ ] Not at all [ ] Mildly [ ] Moderately [ ] Severely [ ] Extremely |
| **Please indicate the source of the pain**Click here to enter text. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Today’s Date**Click here to enter a date. |
| **Substance Use History/Current Use**(Please check and complete appropriate columns) |
| **Which of the following have you used?** | **Age first used**  | **Age last used** | **Frequency of use** |
|  [ ] Beer |   |   |   |
|  [ ] Wine |   |   |   |
|  [ ] Liquor |   |   |   |
|  [ ] Heroin |   |   |   |
|  [ ] Barbiturates |   |   |   |
|  [ ] Amphetamines |   |   |   |
|  [ ] Crack |   |   |   |
|  [ ] Cocaine |   |   |   |
|  [ ] Marijuana/Hashish |   |   |   |
|  [ ] LSD |   |   |   |
|  [ ] Inhalants |   |   |   |
|  [ ] PCP |   |   |   |
|  [ ] MDMA (XTC) |   |   |   |
|  [ ] Prescription drugs off the street |   |   |   |
|  [ ] Non-prescription drugs by injection |   |   |   |
|  [ ] Other |   |   |   |
| **Caffeine** | **Nicotine** |
|  Cups of caffeinated coffee per day |  Packs of cigarettes per day |
|  Cups of caffeinated tea per day |  Other nicotine products per day |
|  Cups of caffeinated soft drinks per day |  Other Use:  |
|  Ounces of chocolate per day |   |
| **Print Name of Person Completing This Questionnaire**Click here to enter text. | **Signature of Person Completing This Questionnaire**Click here to enter text. | **Date**Click here to enter a date. |
| **Clinician Reviewer Comment** (if any) [ ] Medical Review NeededClick here to enter text. |
| **Print Name of Clinician**Click here to enter text. | **Signature of Clinician**Click here to enter text. | **Date**Click here to enter a date. |

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| **Client Name** (First, MI, Last)Click here to enter text. | **Today’s Date**Click here to enter a date. |
| **Comments, Recommendations or Referrals by Medical Reviewer**Check Referral(s) Needed and Specify Action(s) |
|  [ ] No Referral Needed [ ] Primary Care Physician: Click here to enter text. [ ] Healthcare Agency: Click here to enter text. [ ] Specialty Care: Click here to enter text. [ ] Other (specify): Click here to enter text. |
| **Recommendations shared with client?** [ ] No [ ] Yes If yes, client’s response: Click here to enter text. |
| **If no, how will recommendations be shared with client?** Click here to enter text. |
| **Medical Reviewer Signature/Credentials**  [ ] Nurse [ ] PA [ ] NP [ ]  MD [ ] DOClick here to enter text. | **Date**Click here to enter a date. |
| **Client Signature**Click here to enter text. | **Date**Click here to enter a date. |
| **Clinician Reviewing**Click here to enter text. | **Date**Click here to enter a date. |