**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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| 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 interests  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. |
| **Military History**  No Yes If yes, describe branch of service, any pertinent duties, and any trauma experienced during service, as applicable  Click 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) Delinquency  Adult 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 Reported  Click here to enter text. | | **Name and Phone No. of Probation/Parole Officer** (if applicable)  Click here to enter text. | |
| **Civil Proceedings**  None Reported  Click 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 Reported  Click here to enter text. | | | |
| **Child Protective Services Involvement with Family**  None Reported  Click here to enter text. | | | |
| **Name of Children’s Protective Services Caseworker(s) Assigned to Family** (if applicable)  None Reported  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. |
| **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 Needed  Click 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 DO  Click 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. |