**PSYCHOSOCIAL HISTORY**

**CLIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AGE: \_\_\_\_\_ GENDER: \_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_**

Why are you seeking counseling today? Have you had prior counseling or treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **FAMILY & CHILDHOOD HISTORY**

Where were you born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Raised? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your birth order in your family of origin or your main family household? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | **NAME** | **AGE** |
| **BIOLOGICAL MOTHER** |  |  |
| **BIOLOGICAL FATHER** |  |  |
| **ADOPT/STEP MOTHER (if applicable)** |  |  |
| **ADOPT/STEP FATHER ( if applicable)** |  |  |

Were you ever physically, emotionally, or sexually hurt by someone? \_\_\_No \_\_Yes

Did/does anyone in your family have a drug or alcohol problem? \_\_\_No \_\_Yes

Did/does anyone in your family have a chronic physical or mental illness or disability? \_\_\_No \_\_Yes

Did/does anyone in your family have a sexual behavior problem? \_\_\_No \_\_Yes

## RELATIONSHIP& CURRENT FAMILY

Who lives in your current household? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name recent significant changes in your living situation (e.g. divorce, adoption, and job)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Current Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you: \_\_Married \_\_Civil Union/Domestic Partnership \_\_Dating \_\_Living Together

How long have you been together? \_\_\_\_\_\_\_\_\_ Are you satisfied with your relationship? \_\_\_No \_\_Yes

Name recurring relationship issues (e.g. jealousy, infidelity, sexual, violence)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME (S) OF CHILDREN** | **AGE** | **BIO OR STEP** | **OTHER PARENT’S NAME** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

## EDUCATION

Have you ever been suspended or expelled from school? \_\_\_No \_\_Yes

Did you attend special education, Individualized Education Plan or 504 Plan? \_\_\_No \_\_Yes

What is your highest educational level achieved? \_\_\_GED \_\_\_high school \_\_\_college \_\_\_graduate

# **EMPLOYMENT**

Where do you currently work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job title or position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been there? \_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever been fired from a job? \_\_\_No \_\_Yes

# **MILITARY SERVICE**

Branch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years of Service: \_\_\_\_\_\_\_\_\_\_\_\_ Discharge Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Locations of Deployment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Combat: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Commendations/Awards: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **CULTURAL/SOCIAL/SPIRITUAL/ SEXUALTIY**

# How do you identify your race? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your culture? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Faith/Practice\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family of Origin Faith/Practice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you identify your sexual orientation? \_\_\_Heterosexual \_\_\_Homosexual \_\_\_Bisexual \_\_\_Other

### MEDICAL HISTORY

Have you ever had surgery? \_\_\_No \_\_Yes

Do you or others in your life have concerns about your eating or sleeping practices? \_\_\_No \_\_Yes

Do you or others in your life have concerns about your energy level? \_\_\_No \_\_Yes

|  |  |  |
| --- | --- | --- |
| **Major or chronic health problem(s)** | **Age** | **Medications Prescribed** |
|  |  |  |
|  |  |  |
|  |  |  |

**Female:** Age of first period? \_\_\_\_ How many pregnancies? \_\_\_\_ Terminated pregnancies? \_\_\_\_\_\_

How many live births? \_\_\_ Are you pregnant? \_\_\_No \_\_\_Yes Completed menopause? \_\_\_No \_\_\_Yes

## MENTAL HEALTH HISTORY

If you have been treated for a mental health diagnosis, what was it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the treatment or medication prescribed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or others in your life have concerns about your memory or ability to concentrate? \_\_\_No \_\_Yes

Are you noticeably more moody or irritable in the past few months? \_\_\_No \_\_Yes

Have you ever practiced self-injurious behavior, such as cutting or scarring? \_\_\_No \_\_Yes

Have you ever thought about or attempted to harm yourself or someone else? \_\_\_No \_\_Yes

**SUBSTANCE ABUSE & BEHAVIORAL COMPULSIONS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of substance** | **1st Used** | **Last use** | **Describe use** |
| MARIJUANA |  |  |  |
| COCAINE, CRACK |  |  |  |
| STIMULANTS: Methamphetamine, Ice, Dexedrine |  |  |  |
| OPIATES: Heroin, Codeine, OxyContin, Percocet, etc. |  |  |  |
| DEPRESSANTS: Soma, Barbiturates, Quaalude, etc. |  |  |  |
| HALLUCINOGENS: PCP, LSD, Ecstasy, Ketamine, etc. |  |  |  |
| INHALANTS:Glue, White Out, Paint Thinner, etc. |  |  |  |
| ALCOHOL |  |  |  |
| NICOTINE: Cigarettes, Cigars, Chew, etc. |  |  |  |

Have you ever felt as though your drinking or drug use was out of control? \_\_\_No \_\_Yes

Have you ever experienced shakes, nausea, irritability, anxiety, seizure, etc. if you have gone without drinking or using a drug? \_\_\_No \_\_Yes

Is there an increase in the frequency or amount of your drinking or drug use? \_\_\_No \_\_Yes

Have you ever had a blackout? \_\_\_No \_\_Yes if so, what age: \_\_\_\_

Has anyone told you that your behavior changes when you are drinking or using drugs? \_\_\_No \_\_Yes

Has anyone ever told you that you should stop drinking or using drugs? \_\_\_No \_\_Yes

Do you have any alcohol-related medical issues, such as liver disease or pancreatitis? \_\_\_No \_\_Yes

Has your drinking or drug use ever caused problems in school, work, family, friends? \_\_No \_\_Yes

Have you ever felt out of control with a behavior, like gambling, spending, eating, sex? \_\_\_No \_\_Yes

Do you engage in high risk sexual behaviors e.g. unprotected sex, anonymous sex, etc.? \_\_\_No \_\_Yes

Has your sexual behavior gotten you into trouble or caused you shame? \_\_\_No \_\_Yes

# **LEGAL/OTHER HISTORY**

Have you ever been arrested for anything beyond traffic violations? \_\_\_No \_\_Yes

Has anyone ever placed a restraining order or order of protection against you? \_\_\_No \_\_Yes

Do you have an OOP? \_\_\_No \_\_\_Yes, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Two personal strengths? 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Two weaknesses, challenges, or barriers? 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What else can you think of that would be helpful for me to know about you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Counselor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**