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Psychosocial History

Client Name ____
D.O.B.: _______ Age: ________ Sex: _______ Race: _______ Marital Status: _______
Data Source: _____ Patient _____Family Member(s) (specify) ____________________
Other (specify) ____
Disability: _____Mental _____Health ______Alcohol _____Drug

CHILDHOOD AND FAMILY HISTORY

Birth Order: ____
Family of Origin: Number of Brothers: ______ Number of Sisters: _______
Family Members Name Marital Status Check if Deceased
Father
Stepfather
Mother
Stepmother
Siblings
Other Clinically Significant Information Regarding Parents and/or Siblings: __________
____
____
Nature of Current Relationship with Family Members: ___________________________
____
____
Special Care Situation of Childhood: (check all that apply)
___Adoption: Age____
___ Foster Care: Age and Duration: ____
___Institutional Care: Age and Duration: ______________________________________
___Resided with Relatives: Age and Duration: __________________________________
Other Significant Information and Comments Regarding Special Care Situations of Childhood: ____
____
____
Significant Childhood Stressors: (check all that apply)
___Death of Parent: Client Age _____ ___ Death of Sibling: Client Age _________
___Divorce: Client Age: _________ ___ Physical/Sexual Abuse: Client Age: ___
___Domestic Physical Violence
___Family Alcoholism/Drug Abuse/Dependency: ___One Parent ___Both Parents
___Other Childhood Trauma: (specify) ____
CURRENT LIVING SITUATION: (check all that apply)
Resides: ___Alone ___Spouse ___Foster Parents ___Extended Family

___Group Home ___Parents ___Boyfriend/Girlfriend
___Single Parent (specify) ____
___Other (specify) ____
Other Significant Information and Comments Regarding Living Situation: ____________
____
____

MARITAL AND/OR COHABITATION STATUS AND HISTORY (if applicable)
Marital Status: _____________________ Age First Married: _____________________
Marital History: (starting with current relationship)

Name Length of Marriage/Relationship Children in this Marriage/Relationship (First Names and Ages) Identify Problems in this Marriage/Relationship (e.g. financial, social, sexual, etc.)

Other Information and Comments Regarding marital and/or Cohabitation Status and History: ____
____
____

EDUCATIONAL HISTORY
Number of School Years Completed: ________ Diploma/Degree/Certification: ______
Estimate of Academic Performance: ____Below Average _____Average
____Above Average
Exceptional Educational Services Received, Grades Repeated, Number of time Expelled, and other Significant Information: ____
____

EMPLOYMENT HISTORY
Present Status: ___Employed How Long? ______
___ Unemployed How Long? ______
Current Occupation: ____
Summary of Employment History
Occupation Length of Employment Reason for Leaving
Other Significant Information and Comments Regarding Employment History and Current Employment: ____
____

RELIGION (OPTIONAL)
Current religion: __________________________________
Current Religious Involvement: (check most appropriate)
_____High ______Moderate _____Minimal _____None
Other Significant Information and Comments Regarding Religion: __________________
____
____

MEDICAL INFORMATION AND HISTORY
Name of Physician: ____________________ Location of Office: ____________________
Last Physical: __________________ Current Medical Problems Being Treated: ________

____
Current Medications, Including Dosage: ____
____
Significant Prior Medical Problems: (e.g. Operations, Accidents, Serious Illness) ______
____
____
Client's Assessment of Current Medical/Physical Condition: (check most appropriate)
_____Excellent _____Good ______Poor
Other Significant Information and Comments Regarding Medical History and Current Condition: ____
____
____

ALCOHOL AND DRUG USE HISTORY

Client Currently Uses Alcohol and/or Nonprescription Drugs: ___No ___Yes
Alcoholic Beverage Usage: Kind(s) ______________________________________
Amount and Frequency ____________________________
____
Chemical/Drug Usage: Kind(s) ______________________________________
Amount and Frequency ____________________________
____
Client and/or Others Has/Have Been Concerned Regarding Degree of Alcohol and/or Chemical/Drug Usage:
___No ___Yes Explain: ____
____
____
A Formal Alcohol/Drug Assessment is indicated: ___No ___Yes Explain: ____________
____
____

MENTAL HEALTH/ALCOHOL AND DRUG TREATMENT HISTORY

Client Has Received Psychiatric, Psychological, A&D or Related Services in the Past:
___No ___Yes (describe below)
_____Mental Health Treatment _____Alcohol/Drug Treatment
______Both MH and AODA

Source of
Treatment
Year Duration Disability/Condition Outpatient/Inpatient

Specify Beneficial Psychotropic's Previously Utilized: ___________________________

FINANCIAL STATUS Sources of Income: (check all that apply)
___Wages/Salary/Business of Client ___Wages/Salary/Business of Spouse
___AFDC/General Relief ___Veteran's Benefits
___Social Security/SSI/Disability ___Child Support
___Parental Income ___Other: (specify) ___________________
Other Relevant Information and Comments Regarding Financial Status: ______________
____
____

MILITARY HISTORY (If Applicable)

Length of Time Served ________________ Type of Discharge ______________
Branch of Service: ____________________
Reason for Entering the Service ____
____
____
Other Significant Information and Comments Regarding Military History: ____________
____
____

LEGAL STATUS AND HISTORY

Has client ever been arrested? ___Yes ___No Describe Below

Charges, Arrests,
Convictions
Status or Outcome Year Check if A&D Related

Other Significant Information and Comments Regarding Legal Status and History:
____
____
____

SOCIAL/PEER GROUP

Current Degree of Social Interest/Involvement Evidenced by Client:
(Check most appropriate)
_____High _____Moderate _____Minimal _____None
The Overall Quality/Nature of the Client's Social Relationships:
(Check appropriate choice)
_____Superficial ______Conflicted _______Healthy _____Dependent
_____Other (specify) ____
Other Significant Information and Comments Regarding Social Activities, Group Memberships, Interests, and/or Level of Participation: ____________________________
____
____

RECREATIONAL HISTORY

Leisure Time Activities/Interests are: (check most appropriate)
___Well Developed ___Moderately Developed ___Not Developed
Other Significant Information and Comments Regarding Leisure Time Activities/Interest:
____
____
____
Specify Ineffective or Adverse Psychotropic's: __________________________________
____
Other Significant Information and Comments Regarding Prior Mental Health/A&D Treatment: ____
____

SUICIDE HISTORY

Client Has Previously Attempted Suicide: ___No ___Yes (explain): ________________
____
____
Number of Attempts: __________ Date of Most Recent Attempt: ________________
Methods Employed: ____

Other Significant Information and Observations Regarding Prior Suicide Behavior and Current Suicide Risk: ____
____
____

DANGERS TO OTHERS HISTORY

Client has Previously Harmed or Endangered the Health & Safety of Others: ___No
___Yes (explain): ____

Other Significant Information and Observations Regarding Prior Dangerousness and Current Risk of Danger to Others: ____
____
____

OTHER CLINICALLY RELEVANT INFORMATION: (if applicable)
____
____
____
____
____

____ __________________________

Signature Date