Living Life Counseling

ADULT PSYCHO/SOCIAL HISTORY

Name:___________________________________Age:_______Date of Birth____________________________

	FULL NAME	AGE	LIVING WITH YOU
Spouse/Partner			
Children 1.			
2.			
3.			
4.			

What recently happened to make you decide to seek help now? ____________________________________

____

____

What would you like this clinic to do for you? ____

____

____

CLIENT INFORMATION

Marital Status:
[ ] single, never married
[ ] engaged _____ months
[ ] married for _____ years
[ ] divorced for ____ years
[ ] separated for ____years
[ ] divorce in process ____ months
[ ] live-in for _______ years
[ ] ____ prior marriages (self)
[ ] ____ prior marriages (partner)

Intimate Relationship:
[ ] never been in a serious relationship
[ ] not currently in a relationship
[ ] currently in a serious relationship
Relationship Satisfaction:
[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very satisfied with relationship

FAMILY OF ORIGIN:

Present during childhood:

	Present Entire Childhood	Present part of childhood	Not present at all
Mother:	[ ]	[ ]	[ ]
Father:	[ ]	[ ]	[ ]
Stepmother:	[ ]	[ ]	[ ]
Stepfather:	[ ]	[ ]	[ ]
Brother(s):	[ ]	[ ]	[ ]
Sister(s):	[ ]	[ ]	[ ]
Other (specify):	[ ]	[ ]	[ ]

____

Parents' current marital status:

[ ] married to each other for ____ years
[ ] separated for ______ years
[ ] divorced for _______ years
[ ] mother remarried ____ times
[ ] father remarried _____ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for _____ years
[ ] age of client at mother's death _____
[ ] father deceased for ____ years
[ ] age of client at father's death ______

Were you adopted, YES/NO? If so, at what age?__________

ADDITIONAL INFORMATION

Do you have any thoughts now or recently of wishing you were dead?_____ Please explain ________________

____

Do you have any thoughts now or recently of harming yourself? _____ Please explain ___________________

____

Have you ever attempted to harm yourself? ______________ When? _________________________________

Please explain (how, why): ____

Do you have any thoughts now or recently of harming others? _______________________________________

Please explain: ____

Have you ever attempted to kill or seriously harm someone else? ________ Who? _______________________

Please explain: ____

Is your partner afraid of you sometimes? _______________ Please explain: ____________________________

____

Do you ever threaten, throw things, punch walls, slam doors, yell or scream at your partner or children? ______

Please explain: ____

Do you ever hit, slap, or choke any of your loved ones? __________ Who? _____________________________

Please explain: ____

____

How do you feel about your behavior afterward? ____

____

Have you ever been the victim of physical, sexual or verbal abuse? ___________________________________

Please explain: ____

Circle List of Strengths:

Accepts guidance/feedback, capable of independence, clear thinking, confident, creative, empathetic, expressive, articulate, frugal, good personal care habits, insightful, integrated moral values, intelligent, loyal, motivated for change, open minded, organized, outgoing, physically healthy, positive support network, reasonable judgment, reliable, resourceful, responsible, smart, sociable, stable living environment, stable work history, supportive family, trustworthy, varied interests.

Others: ____

Circle List of Weaknesses:

Unstable home environment, very narrow interests, chaotic living, controlling, defensive, dependent, distrustful, hostile, illiterate, impulsive, indecisive, intellectual deficits, irresponsible, lacks insight, lacks moral/ethical values, lacks proper transportation, lacks social skills, needs close supervision, negative peer group, no support network, non-supportive family, not motivated to change, not open/articulate, poor financial resources, poor health, poor hygiene/grooming, poor judgment, procrastination, separated from parents due to abuse/ other legal issues, short tempered, unreliable, unstable employment history.

Others: ____

INTEREST ACTIVITIES (What do you enjoy doing?):

___ television	___ be with friends	___ shop	___ fix/repair things
___ movies/Videos	___ be with family	___ go to school	___ sew/knit/crochet
___ video games	___ be alone	___ study	___ build/decorate
___ music listening	___ cook	___ get high	___ gardening
___ play instrument	___ eat	___ exercise	___ photographing
___ sing	___ go to museum	___ play sports	___ care for elderly/ill
___ dance	___ volunteer work	___ watch sports	___ child-care
___ read	___ travel/site-see	___ hike	___ play cards
___ write	___ prayer/bible read	___ ride bike	___ gamble
___ draw	___ church activities	___ roller-blade	___ sex

EMPLOYMENT, LEGAL, AND FINANCIAL INFORMATION:

Current Employer: ____

Current Position Held: ____

Employment Status:

[ ] employed and satisfied

[ ] employed but dissatisfied

[ ] unemployed

[ ] coworker conflicts

[ ] supervisor conflicts

[ ] unstable work history

[ ] disabled __________

Legal History:

[ ] no legal problems

[ ] now on parole/probation

[ ] arrest(s) not substance – related

[ ] arrest(s) substance – related

[ ] court ordered this treatment

[ ] jail/prison _______ time(s)

total time served ________

Describe last legal difficulty: _______________

____

Financial Situation:

[ ] no current financial problems

[ ] large indebtedness

[ ] poverty or below – poverty income

[ ] impulsive spending

[ ] relationship conflict over finances

EDUCATION: Highest grade completed: ___________________________________ Degree: _____________________

Special training or skills: ____

Hope or plan to go to school? ____

Do you have a learning disability? ____

ETHNIC/CULTURAL NATIONAALITY/BACKGROUND: ____

What religion (denomination) were you raised? ____

What church denomination do you currently attend: ____

Current religious/spiritual involvement/ activities: ____

Do you have any religious or spiritual concerns now? ____

PHYSICAL HEALTH Circle the numbers of all the items that apply to you now or in the past.

1. Allergies
2. Asthma
3. Ulcers
4. Seizures
5. Stomach problems
6. Pancreatitis
7. Liver disease
8. Hepatitis
9. Thyroid problems
10. Chronic fatigue
11. Insomnia
12. Vision problems
13. Speech problems
14. Hearing problems
15. Hypoglycemia
16. Diabetes
17. Low blood pressure
18. Hypertension (high blood pressure)
19. Heart disease
20. Bacterial endocarditic
21. Prolapsed mitral valve
22. Circulation problems
23. Large weight problems
24. Large weight loss
25. Appetite disturbance
26. Sexually transmitted disease
27. HIV positive
28. AIDS
29. Cancer
30. Major Surgery
31. Major Accidents
32. Head Injury
33. Neck Shoulder tension
34. Severe headache/migraine
35. Chronic pain
36. Injury from abuse
37. Broken bones
38. High cholesterol
39. Impotence
40. Irritable bowl

FOR EACH ITEM CIRCLED PLEASE GIVE DATE OF PROBLEM & TREATMENT RECEIVED

(use other sheet it needed)

____
____
____
____
____

Primary Physician's name: ____

Physicians Address: ____ Phone: __________________

Date of last physical: _________________ Results: _______________________________________

List all medications that you are on for medical reasons: ____________________________________

____
____

Do you skip meals often? ______ Eat a well balanced diet? ______ Do you eat much junk food? ____________________

Do you exercise regularly? _____ How often? ______________ What do you do? ________________________________

FOR WOMEN: Number of Pregnancies? _____ Live Birth: _____ Miscarriages: ____ Still births: ___ Abortions: _____

ALCOHOL/DRUG/PRESCRIPTION MEDICATION INFORMATION

SUBSTANCE	AGE OF FIRST USE	AGE OF LAST USE	CURRENT USE YES/NO	FREQUANCY	AMOUNT
Caffeine pills, coffee, cola					
Nicotine, cigarettes					
Beer, Wine					
Liquor/Type					
Marijuana or Hash					
Crack Cocaine					
Cocaine Powder					
Heroin: Snort					
Heroin: Shoot (IV)					
Methadone					
Pain Pills/Type					
Codeine, Tylenol 3, 4 Other:					
Muscle relaxers: Soma, Flexural, Other:					
Tranquillizer: Valium, Librium, Other:					
Inhalants, Glue, Poppers, Aerosols					
PCP, LSD, Mescaline					
Meth-amphetamine, Speed, Ritalin					
Sleeping Pills Codeine					
Steroids					
Prescription Drugs					
Other:					

Which are your drugs of preference: 1. ____________________________ 2. _______________________________

Consequences of substance abuse (check all that apply)

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbances [ ] binges

[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss

[ ] blackouts [ ] tolerance changes [ ] suicidal impulses [ ] arrests

[ ] overdose [ ] loss of control amount used [ ] relationship conflicts [ ] DUI

TREATMENT HISTORY FOR SUBSTANCE ABUSE

If you have had outpatient counseling for substance abuse:

Clinic's name:__________________________ Dates of Service: _____________________________

Therapist's name: ____

If you have had inpatient treatment for substance abuse:

Facility name: __________________________ Dates of Service: _____________________________

Therapist's name: ____

If yes to <u>either</u>, please explain: ____

____

____

TREATMENT HISTORY FOR MENTAL HEALTH

If you have had outpatient counseling for mental health:

Clinic's name: _________________________ Dates of Service: ________________________________

Therapist's name: ____

If you have had inpatient hospitalization for mental health:

Hospital name: _________________________ Dates of Service: ________________________________

Therapist name: ____

If yes to <u>either</u>, please explain: ____

____

____

____ __________________________

Client Signature **Date**

____ __________________________

Therapist Signature **Date**