

Social History

Basic Information

Name:

Address:

DOB:

Phone Number:

Email:

How you heard about me:

Marital Status:

Name of Spouse (if applicable):

Age and sex of each child (if applicable):

Emergency contact and phone number:

Religious and Spiritual

Do you consider yourself spiritual? Yes ___ No ___ Religious? Yes ___ No ___

Do you currently express this spirituality through religious practice? Yes ___ No ___

Would you like spirituality included in your counseling? Yes ___ No ___

Comment:

Background and Presenting Problem

Occupation(s):

If you have been married before, please provide dates for marriage(s) and divorce(s):

Please describe the problem or situation which led you to seek counseling at this time:

How long has this been a problem?

Have you experienced this type of problem before? _____ If so, when?

Have you ever had counseling before? _____ If so, when and why?

Was it helpful? _____ If not, why not?

Have you ever had any medications prescribed for psychiatric or emotional difficulties?

Yes _____ No _____

If so, please list:

Have any other biological relatives had problems similar to yours, or had any other psychiatric or emotional difficulties? Yes _____ No _____

If so, which relatives and what kind of problems?

Presenting Problems: (check all that apply; if attending couples counseling, please put your initials next to the problems that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> very unhappy | <input type="checkbox"/> impulsive | <input type="checkbox"/> parenting problems |
| <input type="checkbox"/> irritable | <input type="checkbox"/> stubborn | <input type="checkbox"/> stealing |
| <input type="checkbox"/> temper outbursts | <input type="checkbox"/> panic attacks | <input type="checkbox"/> repetitive behaviors |
| <input type="checkbox"/> withdrawn | <input type="checkbox"/> lying | <input type="checkbox"/> grief |
| <input type="checkbox"/> daydreaming | <input type="checkbox"/> mean to others | <input type="checkbox"/> employment problems |
| <input type="checkbox"/> fearful | <input type="checkbox"/> destructive | <input type="checkbox"/> financial stress |
| <input type="checkbox"/> worry | <input type="checkbox"/> trouble with the law | <input type="checkbox"/> legal problems |
| <input type="checkbox"/> overactive | <input type="checkbox"/> health problems | <input type="checkbox"/> violence |
| <input type="checkbox"/> slow | <input type="checkbox"/> self-mutilating | <input type="checkbox"/> eating problems |
| <input type="checkbox"/> short attention span | <input type="checkbox"/> stressed out | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> distractible | <input type="checkbox"/> relationship problems | <input type="checkbox"/> sexual problems |
| <input type="checkbox"/> lacks initiative | <input type="checkbox"/> shy | <input type="checkbox"/> drug use |
| <input type="checkbox"/> undependable | <input type="checkbox"/> strange behavior | <input type="checkbox"/> alcohol use |
| <input type="checkbox"/> social problems | <input type="checkbox"/> strange thoughts | <input type="checkbox"/> suicidal thoughts |
| <input type="checkbox"/> crying spells | <input type="checkbox"/> physical abuse | <input type="checkbox"/> homicidal thoughts |
| <input type="checkbox"/> hair pulling | <input type="checkbox"/> sexual abuse | <input type="checkbox"/> hoarding |

Explain:

What are your goals for treatment?

Is there anything else you feel is important for your counselor to know?

