Patient Information & Social History- Adult

Name _____ **Today's Date** _____
Last First MI

Address_____

Home Phone _____ **Work Phone** _____ **Cell**_____

SS# _____ **Birth Date** _____ **Age**_____ **Sex** _____ **Height**_____ **Weight**_____

Emergency Contact Name _____ **Relationship**_____

Address _____ **Phone** _____

Occupation _____ **Employer** _____ **Phone**_____

Employer Address_____

Current Marital Status *(check one)* ___ Single (Never Married) ___ Married Years Married: _____

___ Widowed ___ Separated ___ Divorced ___ Unmarried/Cohabitating Couple

If Married, Spouse _____ **Age**_____ **Phone** _____

Spouse's Address_____

Spouse's Occupation_____ **Employer:**_____

List the members of your family and all others living in your home

Name	Current Age/Birth date	Relationship

Please check any of the following problems that pertain to you:

___Nervousness	___Depression	___Fears	___Shyness
___Sexual Problems	___Suicidal Thoughts	___Separation	___Divorce
___Finances	___Drug Use	___Alcohol Use	___Friends
___Anger	___Self-Control	___Unhappiness	___Sleep
___Stress	___Work	___Relaxation	___Headaches
___Legal Matters	___Memory	___Ambition	___Energy
___Insomnia	___Tiredness	___Making Decisions	___Loneliness
___Inferiority Feelings	___Insomnia	___Education	___Career Choices
___Health Problems	___Temper	___Nightmares	___Marriage
___Children	___Appetite	___Stomach Trouble	
___Bowel Troubles	___Being a Parent	___My Thoughts	

HEALTH HISTORY

Primary Care Physician_____ **Phone** _____

Address _____

Date of last visit _____ **Current Health Problems** _____

List all current medications and dosages _____

Do you have any allergies? ___ No ___ Yes **If yes, describe** _____

In the past 2 weeks were your sleep patterns *(Check one)* ___ Typical or ___ Unusual
Check all that apply: __ Nightmares __ Insomnia __ Early morning waking __ Difficulty falling asleep __ Restless

In the past 2 weeks were your daily eating habits *(Check one)* ___ Typical or ___ Unusual
Check all that apply: ___ 1-2 meals ___ 2-3 meals ___ snacks

Do you have any current or past eating disorders? ___ No ___ Yes **If yes, explain**_____

_____

Are you presently experiencing emotions and/or moods that affect your day to day functioning?
(Check one) ____ Never ____ Seldom ____ Often (6 times a year)
(Check all that apply) ____ Anxiety ____ Frustration ____ Manic states ____ Depression

COUNSELING HISTORY

Previous Psychiatric or Psychological Services: ____Yes ___ No

Treatment Provider: _____ **Phone:** _____

Address: _____

Reason you were seeking care: _____

Treatment outcome: _____

List any support groups you attend _____

Is there a family history of *(Check all that apply)* ____ Alcoholism ____ Substance Abuse ____ Mental Illness

Has anyone in your family been treated for a psychiatric disorder? ____ No ____ Yes **If yes, explain**____

_____

DRUG/ALCOHOL HISTORY

Have you ever used alcohol and/or drugs to change or alter your behavior or mood? ___ No ___ Yes
If yes, explain: _____

Have you ever been charged with DWI/DUI? ___ No ___ Yes **If yes, please explain** _____

_____

Complete the following for family members who use or have a history of alcohol/drug abuse

Family Member	**Substance Used**	**Current Use (yes or no)**	**Treatment Received**

FAMILY & SOCIAL HISTORY

FATHER: *Please answer questions as it was during your childhood*
Occupation _____ **Highest Level of Education**_____
Emotional Health ___ Good ___ Fair ___ Poor **Physical Health** ___ Good ___ Fair ___ Poor
Describe your father/child relationship _____

MOTHER: *Please answer questions as it was during your childhood*
Occupation _____ **Highest Level of Education**_____
Emotional Health ___ Good ___ Fair ___ Poor **Physical Health** ___ Good ___ Fair ___ Poor
Describe your mother/child relationship _____

With whom did you live during your childhood? _____**Where did you grow up** _____

List brothers and sisters (including you) in birth order and give their current ages:

_____ _____ _____ _____

Describe your childhood *(Check one)* ____ Happy ____ Unhappy ____ Mixed
Explain _____

Describe your adolescence *(Check one)* ____ Happy ____ Unhappy ____ Mixed
Explain: _____

Were you abused? ___ No ___ Yes *(Check all that apply)* ___ physically ___ emotionally ___ verbally ___ sexually

EDUCATIONAL HISTORY

Indicate your highest level of education _____

Did you have difficulty in school? ___ Yes ___ No If yes, explain_____

Describe any specialized skills for which you have training, certification or licensure

_____

VOCATIONAL STATUS

Describe your employment history for the past five years beginning with your current position

Employer	Position	Time in Job	Reason for leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any physical/emotional problems that prevent your being employed

_____

JOB PERFORMANCE

Has your employer or supervisor ever expressed any of the following concerns to you? *(Check all that apply)*

____ Missing too much work	____ Assigned tasks not completed	____ Irresponsibility
____ Poor/bad attitude	____ Difficulty getting along with others	____ Late too often
____ Attitude/behavior change	____ Difficulty getting along with supervisors	____ Increased errors

MILITARY HISTORY

Have you ever served in the military service? ___ No ___ Yes **If yes when? From**_____ **To**_____
Which branch_____ **Rank at discharge** _____
Did you ever serve in combat? __ No ___ Yes **If yes, describe** _____
_____

LEGAL HISTORY

Do you have any pending legal action? ___ No ___ Yes **If yes, please explain** _____

_____

Are you currently on probation and/or parole? ___ No ___ Yes **If yes, please explain**_____

_____

LEISURE, RECREATIONAL INTERESTS & HOBBIES

Would you consider your life as *(Check Yes or No for each area)*

Work oriented	____ Yes	____ No	Family oriented_	____ Yes	____ No
Self oriented	____ Yes	____ No	People oriented	____ Yes	____ No
Leisure oriented	____ Yes	____ No	Recreation oriented	____ Yes	____ No

Activities you enjoy doing by yourself _____