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Client Name: _____

PSYCHOSOCIAL HISTORY ASSESSMENT

*****PLEASE REALIZE THAT THIS INFORMATION WILL BE KEPT CONFIDENTIAL. FOR ALL QUESTIONS LISTED BELOW, ANSWER ALL, AND CHECK AND CIRCLE ALL THAT APPLY. IF THE ISSUE DOES NOT APPLY TO YOU, PLEASE INDICATE THIS. PLEASE BE AS HONEST AND AS DETAILED AS POSSIBLE.*****

PRESENTING PROBLEM:

Why did you come to treatment at this time and not before? _____

HISTORY OF PRESENTING ILLNESS

Please describe the history relating to current issues, including recent events &/or physical issues that contribute to your current issues:

Any current physical issues? No Yes; if yes, please explain _____

Previous Psychiatric or CD Treatment? No Yes; if yes, please check all that apply and complete below:

<input type="checkbox"/> Inpatient	Date(s): _____	Diagnosis: _____	Provider: _____
	Date(s): _____	Diagnosis: _____	Provider: _____
<input type="checkbox"/> Residential	Date(s): _____	Diagnosis: _____	Provider: _____
<input type="checkbox"/> PHP	Date(s): _____	Diagnosis: _____	Provider: _____
<input type="checkbox"/> IOP	Date(s): _____	Diagnosis: _____	Provider: _____
<input type="checkbox"/> Psychiatrist	Date(s): _____	Diagnosis: _____	Provider: _____
	Date(s): _____	Diagnosis: _____	Provider: _____
<input type="checkbox"/> Individual	Date(s): _____	Diagnosis: _____	Provider: _____
Therapy	Date(s): _____	Diagnosis: _____	Provider: _____
<input type="checkbox"/> Marital	Date(s): _____	Diagnosis: _____	Provider: _____
<input type="checkbox"/> Family	Date(s): _____	Diagnosis: _____	Provider: _____
<input type="checkbox"/> Other:	_____		

Have you ever had any of the following issues:

Suicide:		Homicide:		Violence:		Self Harm:	
Current:	Past:	Current:	Past:	Current:	Past:	Current:	Past:
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> Ideation	<input type="checkbox"/> Ideation	<input type="checkbox"/> Ideation	<input type="checkbox"/> Ideation	<input type="checkbox"/> Ideation	<input type="checkbox"/> Ideation	<input type="checkbox"/> Ideation	<input type="checkbox"/> Ideation
<input type="checkbox"/> Intent	<input type="checkbox"/> Intent	<input type="checkbox"/> Intent	<input type="checkbox"/> Intent	<input type="checkbox"/> Intent	<input type="checkbox"/> Intent	<input type="checkbox"/> Intent	<input type="checkbox"/> Intent
<input type="checkbox"/> Plan	<input type="checkbox"/> Plan	<input type="checkbox"/> Plan	<input type="checkbox"/> Plan	<input type="checkbox"/> Plan	<input type="checkbox"/> Plan	<input type="checkbox"/> Plan	<input type="checkbox"/> Plan
<input type="checkbox"/> Attempt	<input type="checkbox"/> Attempt	<input type="checkbox"/> Action	<input type="checkbox"/> Action	<input type="checkbox"/> Action	<input type="checkbox"/> Action	<input type="checkbox"/> Action	<input type="checkbox"/> Action

If yes to current suicidal/homicidal/self harm thoughts, describe the plan, means, who can remove the means, etc. _____

Do you own a gun? No Yes; if yes, is it in your possession? No Yes; if yes, who can remove/lock up the gun? (Please list person's name)

History of Suicide?	History of Homicide?	History of Violence?	History of Self Harm?
<input type="checkbox"/> No previous attempt	<input type="checkbox"/> No previous attempt	<input type="checkbox"/> No previous attempt	<input type="checkbox"/> No previous attempt
<input type="checkbox"/> Number of attempts: date(s), means, outcome:	<input type="checkbox"/> Number of attempts: date(s), means, outcome:	<input type="checkbox"/> Number of incidences: date(s), means, outcome:	<input type="checkbox"/> Number of incidences: date(s), means, outcome:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What has kept you in the past from committing suicide or other acts of violence toward yourself or others?

religious beliefs family fear therapy medicine support groups children other:

Is there a history of suicide in your family/support network? No Yes; if yes, who, when, where, how, outcome

ALCOHOL AND DRUG HISTORY:

Current alcohol use: No Yes Current Illegal drug use: No Yes Current Medication Abuse: No Yes

Past use of Alcohol: No Yes Past use of Illegal drugs: No Yes Past abuse of Medicine: No Yes

(If yes to any – please complete the following)

Substance	Age First Used	Last Use	Pattern of Use (Amount, Frequency, Duration, Route, Source)

Changes in pattern of use? No Yes If yes, date of change _____ less more; why: job loss divorce
 death in family financial problems legal problems separation other:

Date(s) of longest period of abstinence?

History of 12 step attendance? No Yes If yes, what type of 12 step meeting(s)? _____ If currently attend, home group: _____ sponsor: _____

If you have quit attending 12 step meetings, why?

History of Withdrawal Symptoms: none reported AM alcohol/drug use agitation anxiety DTs depression
 hallucinations high blood pressure suicidal ideation insomnia shakes nausea tremors violence
 seizures excessive sweating shortness of breath vomiting other:

History of Symptoms of Intoxication: none reported black outs bumps/bruises chest or heart pain confusion
 distended abdomen hallucinations high blood pressure liver problems loss of appetite paranoia red face or nose
 slurred speech swelling vision problems weight loss other:

History of Significant Incidents in Relationship to Alcohol & Drugs none identified family problems work problems
 legal problems money problems health problems automobile accidents other

Living environment: Do the people you live with drink or use drugs? No Yes, if yes, describe: _____

LEGAL SYSTEM INVOLVEMENT If yes, please list when, what for, charges, outcome, etc.

<input type="checkbox"/> arrest(s)	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____
<input type="checkbox"/> domestic violence	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____
<input type="checkbox"/> jail	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____
<input type="checkbox"/> prison	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____
<input type="checkbox"/> probation	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____
<input type="checkbox"/> parole	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____
<input type="checkbox"/> pending charges	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____

FAMILY BACKGROUND

Childhood family: Please list the following:				
Mother	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Location:	<input type="checkbox"/> Adoptive <input type="checkbox"/> Biological	Level of Support:
Father	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Location:	<input type="checkbox"/> Adoptive <input type="checkbox"/> Biological	Level of Support:
Stepmother(s)	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Location:	<input type="checkbox"/> Adoptive <input type="checkbox"/> Biological	Level of Support:
Stepfather(s)	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Location:	<input type="checkbox"/> Adoptive <input type="checkbox"/> Biological	Level of Support:
Brother(s) #: Name & Age:	<input type="checkbox"/> Living <input type="checkbox"/> Deceased Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location:	<input type="checkbox"/> Adoptive <input type="checkbox"/> Biological <input type="checkbox"/> Step	Level of Support:
Sister(s) #: Name & Age:	<input type="checkbox"/> Living <input type="checkbox"/> Deceased Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location:	<input type="checkbox"/> Adoptive <input type="checkbox"/> Biological <input type="checkbox"/> Step	Level of Support:

Did anyone in your family have the below issues, or did you have any of the below issues when you were a child:	
Alcohol or Drug Problems? <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> myself <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> brother <input type="checkbox"/> sister <input type="checkbox"/> grandfather <input type="checkbox"/> grandmother <input type="checkbox"/> aunt <input type="checkbox"/> uncle <input type="checkbox"/> other:
Mental Health Issues? <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> myself <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> brother <input type="checkbox"/> sister <input type="checkbox"/> grandfather <input type="checkbox"/> grandmother <input type="checkbox"/> aunt <input type="checkbox"/> uncle <input type="checkbox"/> other:
Physical Abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> myself <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> brother <input type="checkbox"/> sister <input type="checkbox"/> grandfather <input type="checkbox"/> grandmother <input type="checkbox"/> aunt <input type="checkbox"/> uncle <input type="checkbox"/> other: By who?
Emotional Abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> myself <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> brother <input type="checkbox"/> sister <input type="checkbox"/> grandfather <input type="checkbox"/> grandmother <input type="checkbox"/> aunt <input type="checkbox"/> uncle <input type="checkbox"/> other: By who?
Sexual Abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> myself <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> brother <input type="checkbox"/> sister <input type="checkbox"/> grandfather <input type="checkbox"/> grandmother <input type="checkbox"/> aunt <input type="checkbox"/> uncle <input type="checkbox"/> other: By who?
Have you ever physically, emotionally or sexually abused someone? <input type="checkbox"/> No <input type="checkbox"/> Yes; if yes, please explain:	

Please describe your childhood, including what it was like to grow up in your house: _____

Developmental Issues: milestones within normal limits significant development delays truancy non-parental custody
 delinquency aggression played with fire wet the bed cruelty to animals other behavioral problems foster care
 group home learning disability other:

Education level: less than 12 years GED alternative school detention suspended special education High School diploma some college Bachelors degree Masters Degree Doctorate trade school currently in school other:

Desire for further education? No Yes; if yes, in what area(s)?

CURRENT LIVING ARRANGEMENTS/ENVIRONMENT

Who do you currently live with? homeless alone spouse significant other child(ren) parents in laws
 roommates friends other:

What is it like living in your home? stable unstable Please describe: _____

RELATIONSHIP/MARITAL HISTORY

Sexual Orientation: heterosexual homosexual bisexual transsexual other:

Describe current relationship: Name: _____ Length of time together: _____
 dating married common law cohabitating separated other: _____
 Describe the relationship: stable supportive unsupportive abusive platonic conflicted: (money child rearing sex chores religion infidelity politics mental health issues alcohol/drug abuse friends/family use of time other: _____)

Past Relationship history: Have you been in a romantic relationship in the past? No Yes; if yes, please complete:
 1. Length of time together _____ dating cohabitating common law married married divorced (how long _____) abusive (if yes, how? _____) children together children live with ex no contact now other:

2. Length of time together _____ dating cohabitating common law married married divorced (how long _____) abusive (if yes, how? _____) children together children live with ex no contact now other:

3. Length of time together _____ dating cohabitating common law married married divorced (how long _____) abusive (if yes, how? _____) children together children live with ex no contact now other:

What other sources of support do you have besides your family? _____

Children: None Yes, please list both biological, adoptive and step-children:

<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Biological <input type="checkbox"/> Step	<input type="checkbox"/> Living <input type="checkbox"/> Deceased Age: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location:	State of Relationship:
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Biological <input type="checkbox"/> Step	<input type="checkbox"/> Living <input type="checkbox"/> Deceased Age: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location:	State of Relationship:
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Biological <input type="checkbox"/> Step	<input type="checkbox"/> Living <input type="checkbox"/> Deceased Age: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location:	State of Relationship:
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Biological <input type="checkbox"/> Step	<input type="checkbox"/> Living <input type="checkbox"/> Deceased Age: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location:	State of Relationship:

GRIEF/LOSS ISSUES

No Yes recent death in family (who? _____ when? _____) unresolved deaths from the past (who? _____ when? _____) job loss divorce end of relationship other:

SOCIOECONOMIC/CULTURAL STATUS

Leisure and recreation activities: none movies restaurants reading music games friends crafts children hobbies drinking/drugs sports: _____ other: _____

Religious preference: none Christian Catholic Baptist Jewish Muslim Mormon other:

Cultural/Ethnic issues: None Yes; if yes, describe: _____

VOCATIONAL STATUS/HISTORY & MILITARY HISTORY

military current/history: No Yes; when? _____ Type of discharge: _____
 currently employed? Employer: _____
 How long? _____ Position: _____
 on leave? Since when? _____ Why? _____
 facing lay off/termination: When? _____ Why? _____
 recently laid off or fired: When? _____ Why? _____
 unemployed: How long? _____ Usual type of work: _____

 disabled: SSDI VA other short term disability other long term disability:

