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## Psychosocial History

**Note: If you were a patient here before, please fill in only the information that has changed.**

### A. Identification

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### B. Chief Concern

Please describe the main difficulty that has brought you to see me [please focus on your INDIVIDUAL not relationship issues, with any precipitating events(i.e. depression, anger)]: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you want to see happen as a result of your counseling here? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### C. Person-Centered Planning (These will help us to help you develop your individual plan of service or supports and to choose the services that you want and need).

What are your strengths? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What are your hopes and dreams for the future? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have any interests, hobbies, or special activities that you enjoy? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does faith/religion play a part in your life? Yes \_\_\_ No \_\_\_

If so, do you want to involve these values in your counseling here with us? Yes \_\_\_ No \_\_\_, Please explain:

\_\_\_\_\_  
\_\_\_\_\_

How do you get along with your present spouse or partner? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How do you get along with your children? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Your important friends, past and present:

Names	Good Parts of Relationship	Bad parts of Relationship

Who (if anyone) would you like to bring to your treatment planning meeting at session #2 to involve in your goal setting? \_\_\_\_\_

**D. Treatment**

1. Have you ever received psychological or psychiatric or counseling services before or have been hospitalized for emotional issues?  No  Yes  
 If yes, please indicate:

When?	From whom?	For what?	With what results?

2. Have you ever taken in the past or present any medications for psychiatric or emotional problems?  
 No  Yes If yes, please indicate:

When?	From whom?	Which medications?	For what?	With what results?

**E. Safety**

1. Have you ever seriously thought of suicide or hurting yourself? If so, when? How? \_\_\_\_\_

2. Have you ever seriously thought of hurting someone else? If so, when? How? \_\_\_\_\_

3. Crisis Planning:

What are the symptoms that indicate that you need help in making decisions for yourself (e.g neglecting personal hygiene, abusive and destructive behavior, addictions, not getting out of bed, not eating or drinking enough) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who do you want making decisions for you in case of crisis (please name five if you can) and who do you not want involved? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name your physician, pharmacist, and other healthcare providers with their phone numbers if you can:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What hospital would you prefer to be taken to in a crisis? \_\_\_\_\_

What treatment programs would you like in time of crisis? \_\_\_\_\_  
\_\_\_\_\_

What treatment programs would you avoid in times of crisis? \_\_\_\_\_  
\_\_\_\_\_

In times of crisis, which medications would:

You prefer \_\_\_\_\_

You accept \_\_\_\_\_

You avoid \_\_\_\_\_

What do you need from your supports when in crisis (i.e. hold me, listen to me, encourage me, help me be active)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How can a supporter of yours recognize when you are coming out of a crisis and feeling better?  
\_\_\_\_\_  
\_\_\_\_\_

**F. Relationships in your family of origin. Please describe the following:**

1. Your parents' relationship with each other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Your relationship with each parent and with other adults present: \_\_\_\_\_

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3. Your parents' physical health problems, chemical use, and mental or emotional difficulties: \_\_\_\_\_

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3. Your relationship with your brothers and sisters, in the past and present: \_\_\_\_\_

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**G. Abuse history:**  *I was not abused in any way.*  *I was abused.* If you were abused, please indicate the following. For kinds of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molested, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation, etc.

Your age	Kind of Abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

**H. Chemical Use**

1. Have you ever felt the need to cut down on your drinking?  No  Yes
2. Have you ever felt annoyed by criticism of your drinking?  No  Yes
3. Have you ever felt guilty about your drinking?  No  Yes

## Substance Use/Abuse/Dependence Grid

Note any substance(s) and fill in grid (informal or street terms)

SUBSTANCE	ORDER OF PREFERENCE	N/A	FIRST USE (Age) & CIRCUMSTANCES	REGULAR USE/ ABUSE (Age, Amount, Frequency)	HEAVIEST USE (Age, Amount, Frequency)	MOST RECENT USE
ALCOHOL		<input type="checkbox"/>				
AMPHETAMINES: (White Cross, "Meth", Crank, Speed, Bennies, Dexies)		<input type="checkbox"/>				
COCAINE/CRACK: (Coke, Snow, "C", Toots, Rocks)		<input type="checkbox"/>				
HALLUCINOGENS: (Acid, Angel Dust, MDA, Peyote, Magic Mushrooms, PCP/Phencyclidine)		<input type="checkbox"/>				
MARIJANA/HASHISH - may be assessed as an anagesic and/or a hallucinogen. (Grass, Reefer, Dobies, Smoke)		<input type="checkbox"/>				
OPIOIDS/NARCOTICS: (Morphine, Coedine, Heroin, Darvon, Other: _____) (8-Balls, 222's, "H", "Smack", "Junk")		<input type="checkbox"/>				
SEDATIVES/ HYPNOTICS/ ANXIOLYTICS: (Xanax, Valium, Other _____) ("Ludes", Downers, "14's", Yellow Jackets, Tranks)		<input type="checkbox"/>				
OTHER: Caffeine, Nicotine, OTC		<input type="checkbox"/>				

**I. Legal History**

1. Are you presently suing anyone or thinking of suing anyone?  No  Yes If yes, please explain:

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2. Are you required by a court, the police or a probation/parole officer to have this appointment?

No  Yes If yes, please explain: \_\_\_\_\_

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3. List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones. Under "Jurisdiction write in a letter: (F = Federal, S = State, Co = County, Ci = City). Under "Sentence", write in the time and type of sentence you served or have to serve (AR = accelerated or alternate resolution, CS = Community Service, F – Fine, I – Incarceration, Pr = Probation, Po = Parole, O = Other, R = Restitution.

Date	Charge	Jurisdiction (F, S, C, Ci)	Sentence (AR, I, Pr, Pa)	Probation/Parole officer's name	Your attorney's name

4. Your current attorney's name: \_\_\_\_\_ Phone: \_\_\_\_\_

5. Do you have any weapons at home?  No  Yes

6. Have you ever been incarcerated or on probation?  No  Yes

7. Are there any other legal involvements I should know about? \_\_\_\_\_

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**J. Other**

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

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*This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*