

Previous employment in the past five years: _____
 Employment Satisfactory? [] Yes [] No If no, why? _____

Social/Lifestyle/Medical History

Symptom Checklist (rate your symptoms at their current level)

None: This symptom is not present at this time

Mild: Impacts quality of life, but no significant impairment of day-to-day functioning

Moderate: Significant impact on quality of life and/or day-to-day functioning

Severe: Profound impact on quality of life and/or day-to-day functioning

Symptoms	None	Mild	Moderate	Severe	Symptoms	None	Mild	Moderate	Severe
aggressive behaviors					hopeless				
agitation					hyperactivity				
alcohol to excess					irritability				
anorexia					laxative/diuretic abuse				
anxiety					mood swings				
appetite disturbance					obsessions/compulsions				
bingeing/purging					panic attacks				
conduct problems					paranoid thoughts				
confused thinking					physically hurt others				
defiant behavior					physically hurt self				
depressed mood					victim of physical harm				
drug abuse					poor concentration				
elevated mood					poor grooming				
excessive fears					sexual dysfunction				
hear strange voice					sexually harmed others				
fatigue/low energy					seeing strange things				
overemotional					significant weight gain/loss				
social isolation					sleep disturbance				
grief					emotionally harmed others				
guilt					suicidal thoughts				

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bowel/bladder disturbance									
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What medications are you currently taking?

Medication & Dosage: _____ Frequency: _____ Physician: _____

Reason for Medication: _____

Medication & Dosage: _____ Frequency: _____ Physician: _____

Reason for Medication: _____

Describe current physical health: [] Good [] Fair [] Poor

Health Concerns	Self	Family	Health Concerns	Self	Family
Allergies			Alzheimer's/Dementia		
Birth Defects			Bronchitis/Asthma		
Cancer			Diabetes		
Caffeine Use/Abuse			Ear Infections/Tubes		
Food Sensitivities			Falls/Accidents		
Emotional/Behavioral Problems			High Blood Pressure		
Heart Disease			Stroke/Coma		
Tyroid Problems			Tuberculosis		
Tobacco Use			Orthopedic Problems		
Alcoholism/Drug/Abuse			Ulcers		
Concussion/Broken Bones			Other Chronic/Serious Health Problems		

Family History

Father:

Full Name: _____

Occupation: _____

Education: _____

General Health: _____

If father is deceased: How many years and age of client at father's death: _____

Mother:

Full Name: _____

Occupation: _____

Education: _____

General Health: _____

If mother is deceased: How many years and age of client at mother's death _____

Parents' current marital status:

_____ married to each other

separated for ___ years

divorced for ___ years

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mother remarried _____ times

father remarried _____ times

Present during childhood:

Family Member	Present	Present Part Of	Not Present
mother			
father			
stepmother			
stepfather			
brother(s)			
sister(s)			
other (specify)			

List Siblings (Brothers & Sisters): _____

Describe childhood family experience:

- outstanding home environment
 - normal home environment
 - chaotic home environment
 - witnessed physical/verbal/sexual abuse toward others
 - experienced physical/verbal/sexual abuse from others
- other _____

Client's age at leaving childhood home: _____ Circumstances: _____

Special circumstances in childhood: _____

Describe any past or current significant issues in other immediate family relationships: _____

Describe any past or current significant issues in intimate (e.g. spousal) relationships: _____

Do you, the client, have a history for any of the following?

Social Concerns	Yes	No	Social Concerns	Yes	No
Chronic Lying			Night Terrors		
Stealing			Distrustful		
Violent Temper			Extreme Worrier		

Fire Setting			Self-Injurious Acts		
Won't Sleep Alone			Impulsive		
Repeats Words or phrases			Easily Distracted		
Not Trustworthy			Poor Concentration		
	Yes	No		Yes	No
Hostile/Angry Mood			Overacting		
Indecisive			Immature		
Bizarre Behaviors			Other Social Concerns		

Legal History

Have you ever been a victim of a crime? No Yes If yes, please explain. _____
 Have you ever been convicted of a felony? No Yes If yes, please explain? _____
 Do you currently have any need of Legal Assistance? No Yes If yes, please explain. _____

Please check all that apply for client:

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: _____

Socio Economic History

Living situation:

adequate housing
 inadequate housing, why? _____

Military history:

Branch in military: _____
 Honorable discharge: Yes No

Financial situation:

no current financial problems
 large indebtedness
 poverty or below-poverty income
 impulsive spending
 relationship conflicts over finances

Social support system:

close relationship with family/friends
 few friends
 substance-use-based friends
 no friends
 distant from family of origin

Church/spiritual/recreational history

Y N
 Do you attend a church/religious group? If yes, where? _____
 Are you active in your church/religious group?
 Describe your relationship with God/Higher Power: _____
 Currently active in community/recreational activities?
 Formerly active in community/recreational activities?
 Currently engage in hobbies? _____
 Misc. _____