John Eikel, MA, LPC

Psychosocial History

Client Name____ Date _______________

Family/Relationship History

Marital status: __Married __ Separated __ Divorced __ Single __ Widowed

Previous marriages: Yes__ No___

Children: (Circle those living in home)
Name, Sex, Age

____

____

Problems in current home: ____

____

Any major health problems, alcohol/drug abuse, other addictive behaviors or mental health issues in your family: ____

____

Client's Parents divorced? Y N   Client age when parents divorced?_______

Client's parents a current problem? Y N Explain____

____

Work/School:

Occupation:_______________________________

Employer/school:____ Length employment or school grade____

Problems related to career/vocation/school? Y N Explain____

____

Military involvement present/past?____

Recreation/hobbies?____

Medical History:

Current prescribed medications/dosage:____

____

Prescribing physician:____

Past hospitalizations, surgeries, medical issues (as related to mental health)________________________

____

Current medical issues:____

None known ______

Abuse/Trauma:

History of being sexually abused? Yes___ No___

History of being physically or verbally abused? Yes___ No ___

Was the abuse reported? Yes___ No___ If yes, to whom?____

History of neglect, exposure to violence or traumatic event? Yes___ No____ If yes explain________________

____

____

Psych Treatment History:

Outpatient: Yes____ No____ Approximate dates from/to and problem/area of concern: __________________

____

Inpatient: History of hospitalizations: For mental/emotional problems, drug/alcohol treatment: Y___ N___

Date(s):____

Reason(s):____

Risk:

Family history of suicide: Yes___ No___ Attempts? Yes___ No ___ Personal history of suicidal thoughts: Yes___ No___ Attempts? Yes___ No ___When attempted: ______

How/Method:____ Current suicidal thoughts: Yes____ No_____ Plan ____

Thoughts of harming another person: Yes___ No____ If yes, explain ______________________________

____

Substance use/abuse/addictions:

Tobacco use: Yes___ No___ Frequency:______________ Quantity:______________

Alcohol use: Yes___ No___ Frequency____ Quantity______ Problem? Yes____ No____

Drug use: Yes___ No___ Frequency____ Quantity ______ type ___________ Problem? Yes___ No___

Arrests for being under the influence of alcohol/drugs? Yes______ No______ #____

Gambling: Yes___ No____ Describe ____

Pornography: Yes___ No____ Describe____

Other addictions: ____

Symptoms

Please check all of the following that apply – place a question mark by those you are unsure of:

___Suicide thoughts	___Flashbacks	___Agoraphobia	___Short attention span
___Suicide attempts	___Low motivation	___Increased emotions	___Procrastination
___Worry	___Tired/fatigued	___Irritability	___Difficulty completing tasks
___Depressed/ sad	___Shortness of breath	___Agitation	___Fights
___Headaches	___Hyper vigilant	___Obsession	___Hyperactive
___Trauma	___Appetite change	___Argues	___Organizational problems
___Discouraged	___Tense/nervous	___Grandiose	___Easily frustrated
___Stomach ache	___Chest pain	___Worthlessness	___Fidgety/restless
___Sweats	___Avoidant	___Obsessions	___Impulsive/reactive
___Nightmares	___Weight loss/gain	___Defiant	___Impatient
___Low energy	___Chest tightness	___Racing thoughts	___Underachievement
___Dizziness	___Nausea	___Hopelessness	___Angry
___Shakes/tremble	___Sleep problems	___Compulsions	___Difficulty coping
___Loss of enjoyment	___Anxiety/nervousness	___Blames others	
___Irritable	___Easily startled	___Forgetful	
___Fear of dying	___Helplessness	___Vindictive	

Client strengths:

Spiritual faith___ Motivation___ Social support ___ Hopefulness___ Honesty ____ Confidence ___ Willingness to take responsibility ___ Accurate self assessment ____

Others____

Some individuals find strength and guidance in their faith and wish to incorporate this into their therapy. If you would like to include your faith as a part of your therapy please mark the appropriate box and indicate your faith and/or denomination: ______________________________Yes______No______