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

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_____