Minds Matter Behavioral Health

Adult Psychosocial History

To assist us in completing our assessment and in planning appropriate services, we need the following information. If some of the questions do not apply to you, please mark N/A. If you are the guardian, please complete the form on the person who is seeking services.

Identifying Information

Client Name: _____

Age: _____ Date of Birth: _____ Sex: _____

Marital Status: ☐ Single ☐ Living Together ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race:

☐ Caucasian ☐ Hispanic ☐ Native American ☐ Asian

☐ African American ☐ Other (describe) _____

Do you have a legal guardian? ☐ Yes ☐ No

Person completing this form: ☐ Self ☐ Parent/Guardian ☐ Referring Professional ☐ Spouse/Significant Other ☐ Other

If person completing this form is not the client, please complete this section.

Informant Name: _____ Phone #: _____

Informant Address: _____

Primary Language: _____ Interpreter Needed: ☐ Yes ☐ No

Referral Source and Reason

Were you referred by? ☐ Physician ☐ Family ☐ Friend ☐ School ☐ Employer ☐ Other (If other, who?) _____

Reason for seeking services: _____

_____

_____

_____

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History of Presenting Problem and Services Desired

When did you first think there might be a problem? _____

_____

_____

What do you think caused the problem? _____

_____

Is the problem worse at certain times, situations, or places? If yes, please explain. _____

_____

_____

Have you had recent life stressors: ☐ Yes ☐ No If yes, specify *(check all that apply)*

☐ job change/loss ☐ Child left home ☐ illness ☐ birth or death of loved one ☐ change in marital status

☐ change in school ☐ death of pet ☐ moved ☐ change in significant relationship ☐ anxiety ☐ depression

What is your response when having life difficulties: (check all that apply)

☐ talk to someone/journal ☐ become depressed ☐ become anxious ☐ eat

☐ withdraw/isolate ☐ become angry/yell ☐ use alcohol/drugs ☐ other (please describe): _____

☐ hit or throw things ☐ engage in physical activity ☐ sleep

Past Psychiatric Treatment History

Past mental health treatment: ☐ Yes ☐ No

If yes, specify where and when: _____

Do you currently have any mental health diagnoses? If so, please list them: _____

_____

Do you have any family history of mental illness? ☐ Yes ☐ No ☐ Unknown

If yes, please describe: _____

_____

Have you ever been hospitalized for mental health reasons: ☐ Yes ☐ No

If yes, when: _____

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Legal History

Legal involvement: ☐ none ☐ past ☐ present Describe: _____

Relevance to current problem: ☐ No ☐ Yes Describe: _____

Family/Social History

List your family members: *(include current family and the family you grew up in. You may use the back of this page if necessary)*

Family Member Name	Age	Relationship to You	Living (L)	Deceased (D)

Any recent changes in family relationship(s): ☐ Yes ☐ No If yes, please describe

_____

_____

Is your family involved in your mental health treatment: ☐ Yes ☐ No

If yes, describe your family's expectations from treatment:

_____

_____

If no, would you like them involved: ☐ Yes ☐ No

Current living situation:

☐ alone ☐ friend ☐ foster home ☐ group home ☐ family ☐ other (describe) _____

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Were there any medical problems/complications during pregnancy or at birth for your mother or you:

☐ Yes ☐ No ☐ Unknown

If yes, please describe: _____

_____

Did you have any developmental delays during childhood ☐ Yes ☐ No ☐ Unknown

If yes, please describe: _____

_____

Rate your appetite: ☐ excessive ☐ good ☐ fair ☐ poor ☐ sporadic

Sexual History:

What is your sexual orientation? _____

Are you comfortable with your sexual orientation? ☐ Yes ☐ No

Any recent changes in sexual frequency/performance? ☐ Yes ☐ No

If yes, explain: _____

Any recent high risk sexual activities: ☐ Yes ☐ No

If yes, explain: _____

Support System/Community Resources

Do you participate in leisure activities/hobbies: ☐ Yes ☐ No If yes, describe _____

_____

Do you have goals for your future: ☐ Yes ☐ No If yes, describe _____

_____

Do you have a support system: ☐ Yes ☐ No If yes, describe _____

_____

Primary Support Person:

☐ friend ☐ spouse/partner ☐ family member ☐ none ☐ Other (describe) _____

_____

Do you use community resources: ☐ Yes ☐ No If yes, describe _____

_____

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Spiritual/Religious Practices/Beliefs:

Religious preference: _____

☐ active ☐ inactive ☐ experiencing spiritual/religious distress Explain: _____

_____

Education and Work History

Name of current school, if applicable: _____ Highest grade completed: _____

School performance:

☐ above average ☐ average ☐ below average

Participation in extra-curricular activities during school years: ☐ Yes ☐ No If yes, specify _____

_____

Have there been any changes in school performance: ☐ Yes ☐ No If yes, explain _____

_____

School Problems: (*check all that apply)*

☐ None ☐ attendance ☐ learning problems ☐ school discipline/behavior problem

Did/Do you receive special education services: ☐ Yes ☐ No

Are you currently employed: ☐ full-time ☐ part-time ☐ No. If yes, indicate position _____

Describe job _____

_____

Length of time at above named job _____ Length of time for longest held job _____

Military Service: ☐ none ☐ past ☐ present Describe: _____

Relevance to current problem: ☐ no ☐ yes Describe: _____

Type of discharge *(if applicable)*: _____

Work problems *(check all that apply)*:

☐ none ☐ attendance ☐ relationships with co-workers/employer

☐ frequent job changes ☐ disciplined/fired ☐ other (describe) _____

Relevance to current problem: ☐ No ☐ Yes Describe _____

_____

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Substance Use

Do you use any of the following *(include use of street drugs and/or prescription drugs)*?

	Age of Onset	Length of Use	Frequency of Use	Present Use	
Nicotine	_____	_____	_____	☐ Yes	☐ No
Caffeine	_____	_____	_____	☐ Yes	☐ No
Alcohol	_____	_____	_____	☐ Yes	☐ No
Heroin	_____	_____	_____	☐ Yes	☐ No
Methadone	_____	_____	_____	☐ Yes	☐ No
Barbiturates	_____	_____	_____	☐ Yes	☐ No
Tranquilizers	_____	_____	_____	☐ Yes	☐ No
Cocaine	_____	_____	_____	☐ Yes	☐ No
Amphetamines	_____	_____	_____	☐ Yes	☐ No
Methamphetamines	_____	_____	_____	☐ Yes	☐ No
Marijuana	_____	_____	_____	☐ Yes	☐ No
Hallucinogens	_____	_____	_____	☐ Yes	☐ No
Inhalants	_____	_____	_____	☐ Yes	☐ No

Which substance do you prefer? *(Drug of choice)* _____

How long was your last period of voluntary abstinence from this substance? _____

Related to any alcohol/drug use, have you ever had:

☐ D.T.'s ☐ Yes ☐ No If yes, when _____

☐ Blackouts ☐ Yes ☐ No If yes, when _____

☐ Convulsions ☐ Yes ☐ No If yes, when _____

☐ Overdose ☐ Yes ☐ No If yes, when _____

Has anyone close to you ever asked you to stop drinking/using drugs? ☐ No ☐ Yes

Have you ever received treatment for drug or alcohol use? ☐ No ☐ Yes If yes, when, and where _____

_____

Attendance at AA/NA ☐ No ☐ Yes If yes, when, and where _____

Describe any substance abuse treatment of other family members _____

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Risk Assessment

Physically abused *(assault, domestic violence, child abuse)* ☐ Yes ☐ No If yes, describe _____

Have you ever been emotionally abused? ☐ Yes ☐ No If yes, describe _____

Have you ever been sexually abused (includes rape and sexual molestation)?

☐ Yes ☐ No If yes, describe _____

Have you ever felt suicidal? ☐ Yes ☐ No If yes, describe _____

Have you ever attempted suicide? ☐ Yes ☐ No If yes, describe _____

Have you ever observed violence in your family? ☐ Yes ☐ No If yes, describe _____

Have you ever had thoughts of harm toward others? ☐ Yes ☐ No If yes, describe _____

When you get angry, how do you respond? *(check all that apply)*

☐ hit things/others ☐ throw things ☐ yell/scream ☐ stew over it

☐ plot revenge ☐ other _____

Strengths and Limitations

What are your strengths: _____

What are your limitations: _____

Is there anything else you would like me to know? _____


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