Spring To Life Counseling, LLC

ADULT PSYCHOSOCIAL HISTORY

Name _____ DOB _____ Date _____

Presenting Problem: _____
_____
_____
_____
_____
_____

Reasons for Seeking Treatment

Please describe current challenges, stressors and reason for seeking therapy:

_____
_____
_____
_____
_____
_____

Please describe your goals and desired outcome for therapy:

_____
_____
_____
_____
_____
_____
_____

Who referred you/ how did you find me:

_____

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? Please tell me here; use the back of the paper if needed.

_____
_____
_____

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Family Composite:

Father ___ Stepfather ___ Mother ___ Stepmother ___ Siblings (#) __ Birth Order ____

Other Family Constellation:

_____
_____
_____

Relationship Status:

Married ___ Divorced ___ Separated ___ Widowed ___ Single ____ Partnered ____

Level of Education:

No schooling ___ Elementary ___ Middle School ___ High School ____ College ___

Master's ___ Doctorate ___ Other (specify) _____

Employment:

None ___

Employed _____

Veteran (Explain if you're on duty or off duty) _____

Other (Explain) _____

Your current employer

Employer: _____

Work phone: _____

Address: _____

Occupation: _____

Length of time with this employer: _____

Please indicate any restrictions on calls: _____

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List of Symptoms

Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (high/low)
extreme fatigue	fears	fetishes
finances	friends	guilt
headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Marriage / Relationship:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

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Family:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Job/school performance:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Friendships:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Financial situation:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Physical health:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Anxiety level / nerves:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Mood:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

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Eating habits:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Sleeping habits:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Sexual functioning:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Alcohol / drug use:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Ability to concentrate:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Ability to control anger:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Client Signature _____ Date _____

Therapist Signature _____ Date _____

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ADULT PSYCHOSOCIAL HISTORY

I. Current Relationship Status

_____
_____
_____

II. Significant Past Relationship Status

_____
_____
_____

III. Family of Origin

_____
_____
_____

IV. Current Support Network

_____
_____
_____

V. Childhood History

a. Trauma(s):

b. Illness(es):

c. Other(s):

VI. Suicidal Assessment

a. Thoughts of Suicide? (recent and past):

b. Attempt(s):

c. Self-Harm:

d. Thoughts of harming others:

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VII. Interests/Hobbies

_____
_____
_____

VIII. Significant Employment History

_____
_____
_____

IX. Education

_____
_____
_____

X. Ethnic/Cultural Identity

_____
_____
_____

XI. Physical Health

_____
_____
_____

XII. Alcohol/Drug Usage

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or non-prescription drugs? Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe:

_____

_____

Discuss any Treatment History:

XIII. Prescription Medication

_____
_____
_____

XIV. Treatment History for Mental Health

_____
_____
_____

If you have had outpatient counseling for mental health:

Clinic's name: _____ Dates of Service: _____

Therapist's name: _____

If you have had inpatient hospitalization for mental health:

Hospital name: _____

Dates of Service: _____ Therapist name: _____

If yes to either, please explain: _____
_____
_____
_____

XV. OTHER INFORMATION

What do you consider to be your strengths?

_____
_____
_____

What do you like most about yourself?

_____
_____
_____

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What are your effective coping strategies regarding the presenting problems?

_____
_____
_____

What other coping strategies do you have to cope with the presenting problems?

_____
_____
_____

Client Signature _____ Date _____

Therapist Signature _____ Date _____