CATHOLIC CHARITIES FAMILY SERVICES **FS-5**

ADULT SOCIAL HISTORY **Rev. 6/14**

***Directions*:** To assist your therapist in completing a prompt and thorough assessment, you are requested to fill out these confidential forms. Please be as complete as possible so that we can best provide the most appropriate services for your needs. Please print.

DATE _____

NAME_____ DATE OF BIRTH_____

ETHNICITY _____ EDUCATION _____ RELIGION _____

***EMERGENCY CONTACT PERSON (NAME/PH #)* _____**

FAMILY DEMOGRAPHICS

Name	***Date of birth***	***Sex***	***Relation to you***	***Occupation:***

Have you ever experienced any pregnancy issues? ☐yes ☐ no Explain (date(s), cause(s) *reaction*)

_____

_____

MARITAL HISTORY

Current Marital Status: ☐ married ☐ separated ☐ divorced ☐ single ☐ widowed ☐ living together

Please give names and dates, if applicable

Marriage(s)_____

Separation(s)_____

Divorce(s)_____

Annulment(s)_____

Death(s) of Spouse(s)/Partner(s)_____

VIOLENCE RELATED HISTORY

☐ Physical Abuse ☐ Sexual Abuse ☐ Domestic Violence ☐ Other ☐ None

_____

_____

_____

LIFESTYLE ISSUES THAT MAY IMPACT TREATMENT

Alcohol usage: ☐ None ☐ In Recovery ☐ Attending 12 step

☐ Social Drinker _____ drinks per day_____ drinks per week _____ drinks per month

Drugs: ☐ None ☐ In Recovery: please specify type of drug(s) used _____

☐ Attending 12 step ☐ currently using, please specify type of drug (s) using _____

Are you concerned at all about your alcohol/drug use? ☐ yes ☐ no
Have others expressed concerns about your alcohol/drug use? ☐ yes ☐ no
If you checked yes to either question, what are the concerns?

_____
_____
_____
_____

Concerns about sexual issues ☐ Avoidant ☐ Compulsive (pornography, internet, at-risk behaviors) ☐Other
If you checked any box, what are your specific concerns?

_____
_____
_____

Concerns about food:
☐ Uncontrolled overeating ☐ Not eating ☐excessive exercise ☐ eating disorder ☐ Other
If you checked any box, what are your specific concerns?

_____
_____
_____

Concerns about money: ☐ Gambling ☐ Compulsive spending ☐ Other _____
If you checked any box, what are your specific concerns?

_____
_____
_____

MEDICAL HISTORY
Current Health: _____
_____
Past major illness, surgeries, accidents (including dates)_____
_____
_____

MEDICATIONS
Medications currently taking Condition being treated

_____
_____
_____
_____
_____

PREVIOUS MENTAL HEALTH TREATMENT
Have you previously received mental health treatment, either outpatient or inpatient? If yes, please give date, location, condition treated, medications prescribed, and any other information you wish to share.
Outpatient
Dates: Location: Medication:
Condition treated: _____
_____
Dates: Location: Medication:
Condition treated: _____

Inpatient
Dates: Location: Medication:
Condition treated: _____

Please list significant medical and psychiatric history of grandparents, parents, siblings, and children.
Medical issues/Mental Health issues/ Addiction issues (include any history of violence, trauma, and/or abuse)

Please add any additional information regarding your social history which you believe is important for us to know_____

ISSUES CHECKLIST

To help us better understand your concerns, please review the following list of issues and check those which apply to you and/or your situation. This information is confidential.

___ Employment problems
___ School problems
___ Legal problems
___ Financial problems
___ Living arrangements
___ Increase/decrease in appetite/weight
___ Confusion
___ Unexplainable and/or uncontrollable crying
___ Extravagance with money
___ Fatigue
___ Forgetfulness
___ Frequent lying
___ Risk taking behavior
___ Generalized dissatisfaction
___ Guilt feelings
___ Difficulty being alone
___ Anxiety that limits activities
___ Mood swings
___ Hyperactivity
___ Panic attacks
___ Sadness/depression
___ Chronic illness
___ Anxious/ worried/nervous
___ Shy, uneasy with others
___ Suicidal thoughts
___ Trouble sleeping
___ Passive behavior
___ Aggressive behavior
___ Unwanted compulsive behavior
___ Withdrawn
___ Worry about alcohol/drug use
___ Worry about eating habits
___ Physically abused
___ Sexually abused
___ Emotionally abused
___ Abuse issues toward others
___ Excessive fighting
___ Sexual problems
___ Sexual identity concerns
___ Physical problems
___ Poor concentration
___ Relationship problems
___with child(ren)
___with spouse
___with significant other
___with other family member(s)
___with peers

Place a check next to any of the following that have happened to you or any immediate family members or others in your household in the last two years:

___ Death of a spouse/partner
___ Death of a close friend
___ Death of a family member
___ Major change in health
___ Marriage
___ School failure
___ Victim of a crime
___ Reconciliation with spouse/partner
___ Separation/divorce
___ Death of a pet
___ Incarceration
___ Pregnancy/new child
___ Unemployment
___ Change of employment
___ Change of residence