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Brief Psychosocial History

Your Name:_____

Date of Birth:_____Age:_____ Gender:_____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced
□ Widowed

Please list any children/age:_____

Address: _____

_____

Phone: hm _____ → ok to leave message? Y / N
wk _____ → ok to leave message? Y / N
cell _____ → ok to leave message? Y / N
other _____ → ok to leave message? Y / N
email _____ → ok to email? Y / N

Do you want a superbill periodically to submit to your PPO insurance? Y / N

How did you hear about my services? _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Have you ever been diagnosed with a mental health condition?
□ No
□ Yes, please specify: _____

Are you currently taking any prescription medication?
□ No
□ Yes
Please list: _____

_____

Name of prescribing physician and phone #: _____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates: _____
Name of prescribing physician and phone #: _____

General Health and Mental Health Information

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:
_____

2. How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:
_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:
_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe: _____

8. Do you drink alcohol? □ No □ Yes
If yes, how often: _____

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:
_____
_____

_____
_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle and List Family Member:

Alcohol/Substance Abuse **yes/no**:_____
Anxiety **yes/no**:_____
Depression **yes/no**:_____
Domestic Violence **yes/no**:_____
Eating Disorders **yes/no:**_____
Obsessive Compulsive Behavior **yes/no**:_____
Schizophrenia **yes/no:**_____
Suicide Attempts **yes/no**:_____

Additional Information

1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation?
_____
Do you enjoy your work? Is there anything stressful about your current work?
_____
_____

2. Are you currently enrolled in school? □ No □ Yes
If yes, where:_____
What do you study:_____

3. What do you consider to be some of your strengths?
_____
_____

4. What do you consider to be some of your weaknesses?
_____
_____

5. What would you like to accomplish out of your time in therapy?
_____