Adult Social and Health History

Client Name (First, MI, Last)	**Today's Date**

Presenting Problem

Why are you seeking treatment today?

How long ago did you begin to be troubled by this problem?

How often do you experience this problem?

When did you first consult a professional (counselor, physician, social worker, etc.)?

Symptom Checklist

Check All Current Problems

☐ **Nutritional/Eating Pattern Changes/Disorders**

As evidenced by:

☐ Self-induced Vomiting	☐ Increase in Appetite	☐ Weight Gain
☐ Binge Eating	☐ Decrease in Appetite	☐ Weight Loss
☐ Use of Laxatives	☐ Excessive Exercising	☐ None

☐ **Pain Management**

As evidenced by:

☐ Pain Interferes with Activities	☐ None

☐ **Depressed Mood/Sad**

As evidenced by:

☐ Loss of Interest in Activities	☐ Hopelessness	☐ Indecisiveness
☐ Empty Feeling	☐ Worthlessness	☐ Recurrent Thoughts of Death
☐ Fatigue/Loss of Energy	☐ Trouble Concentrating	☐ Feeling Sad or Depressed
☐ Thoughts of Harming Yourself	☐ None	

☐ **Grief Issues**

As evidenced by:

☐ Loss of Loved One in Past Year	☐ Other Loss (Describe)	☐ None

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☐ **Anxiety**
As evidenced by:

☐ Excessive Worry ☐ Irritability ☐ Excessive Checking
☐ Restlessness ☐ Compulsions ☐ Strong Fears
☐ Obsessions ☐ Difficulty Breathing ☐ Shaking
☐ Muscle Tension ☐ Pounding Heart ☐ Excessive Handwashing
☐ None

☐ **Traumatic Stress**
As evidenced by:

☐ Recurrent/Intrusive/Distressing Thoughts/Images ☐ Startles Easily ☐ None
☐ Recurrent Dreams/Nightmares ☐ Exposure to Traumatic Event

☐ **Anger/Aggression**
As evidenced by:

☐ Threatens/Intimidates Others ☐ Physically Hurts People ☐ Use of Weapons
☐ Initiates Fights ☐ Physically Hurts Animals ☐ None

☐ **Oppositional Behaviors**
As evidenced by:

☐ Loses Temper ☐ Blames Others ☐ Spiteful/Vindictive
☐ Argues ☐ Easily Annoyed ☐ None
☐ Deliberately Annoys Others ☐ Angry and Resentful

☐ **Inattention**
As evidenced by:

☐ Difficulty Sustaining Attention ☐ Disorganized ☐ Forgetful
☐ Trouble Finishing Things ☐ Easily Distracted ☐ None

☐ **Impulsivity**
As evidenced by:

☐ Difficulty Resisting Impulses ☐ Trouble Waiting for Turn ☐ Frequently Interrupts
☐ None

☐ **Disturbed Reality Contact**
As evidenced by:

☐ Hears Voices Others Don't Hear ☐ Seeing Things Others Don't See ☐ None

☐ **Mood Swings/Hyperactivity**
As evidenced by:

☐ Excessive Movement ☐ Excessive Talking ☐ Rapid or Extreme Changes in Mood
☐ Decreased Need for Sleep ☐ Irritability ☐ Inflated Self-Esteem
☐ None

☐ **Addictive Behaviors**
As evidenced by:

☐ Gambling ☐ Internet ☐ Shopping
☐ Pornography ☐ None

Client Name (First, MI, Last)	**Today's Date**

☐ **Sleep Problems**

As evidenced by:

☐ Difficulty Falling or Staying Asleep ☐ Sleepwalking ☐ Frequent Nightmares

☐ Excessive Sleepiness ☐ None

Sexual Orientation and/or Gender Expression:

☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender ☐ Questioning Other relevant information:

☐ **Stressors**

☐ **Other**

Living Situation

My Home

☐ Rent ☐ Own

****Residential Care/Treatment Facility**

☐ Hospital ☐ Temporary Housing ☐ Residential Care ☐ Nursing Home

****Other**

☐ Friend's Home ☐ Relative's/Guardian's Home ☐ Foster Care Home ☐ Respite Care

☐ Homeless Living with Friend ☐ Homeless in Shelter/No Residence ☐ Jail/Prison **Name of**:

Primary Household

Household Member Names	Relationship To Client	Age	Quality of Relationship (Staff Use Only)

Significant Family Members/ Others not Listed Above	Relationship To Client	Age	Quality of Relationship (Staff Use Only)

Client Name (First, MI, Last)	**Today's Date**

Education, Employment and Military Information

Education History (check all that apply)	**Highest Grade Completed**	**Vocational Year Completed**
☐ GED ☐ HS Graduate ☐ College		

College

_____ No of years, quarters, or semesters

Degree/Major: _____

Other Degrees Completed: _____

History of Learning Difficulties (including performance/behavioral problems due to AOD use)

☐ None reported
☐ Learning Disability Type: _____
☐ Mental Retardation: _____
☐ Special School Placement: _____
☐ Other: _____

Barriers to Learning

☐ None reported ☐ Inability to Read or Write ☐ Other:

Special Communication Needs

☐ None reported ☐ TDD/TTY Device ☐ Sign Language Interpreter ☐ Assistive Listening Device(s)
☐ Language Interpreter Services Needed/Other Spoken Language: _____
☐ Other: _____

Employment (check all that apply)

☐ Full Time (35 hrs. or more per week) ☐ Part Time (less than 35 hrs. per week) ☐ Non-Competitive
☐ Unemployed – date last worked: _____

Not in Labor Force

☐ Disabled ☐ Retired ☐ Homemaker ☐ Student ☐ Living in Institution
☐ Other: _____

If employed, name of employer and job title

Employer: _____ Job Title: _____

Job Performance History

Number of Jobs in Last 5 Years	**Comments** (include performance/behavioral problems due to alcohol or drug use)

Attendance

☐ Above Average ☐ Normal ☐ Tardiness ☐ Absenteeism

Performance

☐ Exemplary ☐ Good ☐ Average ☐ Below Average

Employment Interests/Skills

☐ No ☐ Yes Are you satisfied with your job?
☐ No ☐ Yes (If not currently employed) Do you want to work?
☐ No ☐ Yes Are you experiencing financial problems?
☐ No ☐ Yes Are you concerned that employment will affect your benefits?

Comments on Past or Current Employment/Education Skills/Interests (include information relating to past or current employment/education skills and interests

Client Name (First, MI, Last)	**Today's Date**

Military History

☐ No ☐ Yes If yes, describe branch of service, any pertinent duties, and any trauma experienced during service, as applicable

Type of Discharge (if other than General/Honorable)

Legal History

Legal Guardian/Custodian – Name, Address and Phone Number

☐ None Reported Name: Address: Phone:

Do you have an Advance Directive/Declaration for Mental Health Treatment:

☐ Yes – Please provide a copy to your treatment provider ☐ No, but I would like more information ☐ No, and I am not interested in more information

Current Legal Status

☐ None Reported ☐ On Probation ☐ Detention ☐ On Parole
☐ AoD Related Legal Problems ☐ Conditional Release ☐ Outpatient Commitment ☐ Awaiting Charges
☐ Court Ordered to Treatment ☐ Others:

History of Legal Charges

☐ None Reported
Juvenile: ☐ No ☐ Yes If yes: ☐ Status Offense (e.g., Unruly) ☐ Delinquency
Adult ☐ No ☐ Yes If yes: ☐ Misdemeanor ☐ Felony

List and Date of Most Recent Legal Charges

Convictions

☐ None Reported

Incarcerations	**Name and Phone No. of Probation/Parole Officer** (if applicable)
☐ None Reported	
Civil Proceedings	**Domestic Relations Court Problems** (i.e., custody, protective services, restraining order)
☐ None Reported	

Juvenile Court Involvement (related to child abuse, neglect, or dependency)

Current: ☐ No ☐ Yes Comment: _____

Past: ☐ No ☐ Yes Comment: _____

Children's Support Enforcement Orders

☐ None Reported

Child Protective Services Involvement with Family

☐ None Reported

Name of Children's Protective Services Caseworker(s) Assigned to Family (if applicable)

☐ None Reported

Client Name (First, MI, Last)	**Today's Date**

Adult Health History Questionnaire

This form should be completed as fully as possible by client, but reviewed by medical or clinical staff

Have you had any of the following health problems?

	Now	Past	Never	What Treatment Was Received and Date(s)
Anemia				
Arthritis				
Asthma				
Bleeding Disorder				
Blood Pressure (high or low)				
Bone/Joint Problems				
Cancer				
Cirrhosis/Liver Disease				
Diabetes				
Epilepsy/Seizures				
Eye Disease/Blindness				
Fibromyalgia/Muscle Pain				
Glaucoma				
Headaches				
Head Injury/Brain Tumor				
Hearing Problems/Deafness				
Heart Disease				
Hepatitis/Jaundice				
Kidney Disease				
Lung Disease				
Menstrual Pain				
Oral Health/Dental				
Stomach/Bowel Problems				
Stroke				
Thyroid				
Tuberculosis				
AIDS/HIV				
Sexually Transmitted Disease				
Learning Problems				
Speech Problems				
Anxiety				
Bipolar Disorder				
Depression				
Eating Disorder				
Hyperactivity/ADD				
Schizophrenia				
Sexual Problems				
Sleep Disorder				
Suicide Attempts/Thoughts				
Other:				
Other:				

Please note family history of any of the above conditions and client's relationship to that family member

Client Name (First, MI, Last)	**Today's Date**

Current Medication Information

(medical and psychiatric prescription/OTC/herbal)

☐ None Reported **Please note if certain medication information is not available at time of completion (name, dosage, frequency, etc.)**

Medication	Rationale	Dosage/Route/Frequency	How is it working?
	☐ unknown	☐ unknown	
	☐ unknown	☐ unknown	
	☐ unknown	☐ unknown	
	☐ unknown	☐ unknown	
	☐ unknown	☐ unknown	
	☐ unknown	☐ unknown	

Primary Care Physician (name, phone no., and address) ☐ **No current PCP**

Date of Last Physical Exam

Other Prescribing Physician(s) (name, phone no., and address)

Past Psychiatric Medications

☐ None Reported

Past Psychiatric Medications	How Did it Work/Reason for Stopping/Adverse Reactions

Have you had medical hospitalization/surgical procedures in the last 3 years?

☐ No ☐ Yes If yes, complete information below

Hospital	City	Date	Reason

Do you have any other physical disabilities or disorders that this questionnaire has not addressed, please list. How are these disorders currently interfering in your life?

Allergies/Medication Adverse Reactions/ Sensitivities

☐ None ☐ Food (specify) ☐ Medicine (specify) ☐ Other (specify)

Pregnancy History ☐ Not Pertinent

Currently Pregnant? (If yes, expected delivery date)
☐ No ☐ Yes Expected Delivery Date _____

Receiving Prenatal Healthcare? (If yes, indicate provider)
☐ No ☐ Yes Provider _____

Currently Breastfeeding? ☐ No ☐ Yes

Last Menstrual Period Date

Any Significant Pregnancy History? (if yes, explain)
☐ No ☐ Yes

Client Name (First, MI, Last)	**Today's Date**

Medical Information

Indicate how many times in the past 12 months you have used these medical services:

_____ Hospital admissions

_____ Emergency room visits

_____ Regular visits to doctor

_____ Regular visits to dentist

Have you had any of the following symptoms in the past 60 days? (please check all that apply)

☐ Ankle Swelling	☐ Diarrhea	☐ Nervousness	☐ Tingling in Arms and/or Legs
☐ Bed wetting	☐ Dizziness	☐ Nosebleeds	☐ Tremor
☐ Blood in Stool	☐ Falling	☐ Numbness	☐ Urination Difficulty
☐ Breathing Difficulty	☐ Gait Unsteadiness	☐ Panic Attacks	☐ Vaginal Discharge
☐ Chest Pain	☐ Hair Change	☐ Penile Discharge	☐ Vision Changes
☐ Confusion	☐ Hearing Loss	☐ Pulse Irregularity	☐ Vomiting
☐ Consciousness Loss	☐ Lightheadedness	☐ Seizures	☐ Other: _____
☐ Constipation	☐ Memory Problems	☐ Shakiness	_____
☐ Coughing	☐ Mole/Wart Changes	☐ Sleep Problems	☐ Other: _____
☐ Cramps	☐ Muscle Weakness	☐ Sweats (night)	_____

Immunizations – Have you had or been immunized for the following diseases? (please check all that apply)

☐ Chicken Pox	☐ Diphtheria	☐ German Measles	☐ Hepatitis B	☐ Measles
☐ Mumps	☐ Polio	☐ Small Pox	☐ Tetanus	☐ Other:

Height	**Has client's weight changed in the past year?**
Weight	☐ No ☐ Yes If yes, by how much (+ or -): _____

Nutritional Screening

No Problem	**Eating**	**Drinking**	**Appetite**
☐	☐ More ☐ Less ☐ Not Eating	☐ More ☐ Less ☐ Takes Liquids Only	☐ Increased ☐ Decreased

☐ Nausea ☐ Vomiting ☐ Trouble Chewing or Swallowing

Special Diet	**Other**

Do you use any complementary health approaches (i.e.: meditation, yoga, nutrition, etc.)?

Pain Screening

Does pain currently interfere with your activities? (if yes, how much does it interfere with these activities [please check])

☐ No ☐ Yes ☐ Not at all ☐ Mildly ☐ Moderately ☐ Severely ☐ Extremely

Please indicate the source of the pain

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Substance Use History/Current Use

(Please check and complete appropriate columns)

Which of the following have you used?	Age first used	Age last used	Frequency of use
☐ Beer			
☐ Wine			
☐ Liquor			
☐ Heroin			
☐ Barbiturates			
☐ Amphetamines			
☐ Crack			
☐ Cocaine			
☐ Marijuana/Hashish			
☐ LSD			
☐ Inhalants			
☐ PCP			
☐ MDMA (XTC)			
☐ Prescription drugs off the street			
☐ Non-prescription drugs by injection			
☐ Other			

Caffeine	Nicotine
_____ Cups of caffeinated coffee per day	_____ Packs of cigarettes per day
_____ Cups of caffeinated tea per day	_____ Other nicotine products per day
_____ Cups of caffeinated soft drinks per day	_____ Other Use:
_____ Ounces of chocolate per day	

Print Name of Person Completing This Questionnaire	Signature of Person Completing This Questionnaire	Date

Clinician Reviewer Comments, Recommendations or Referrals

Recommendations shared with client?

☐ No ☐ Yes If yes, client's response:

If no, how will recommendations be shared with client?

Print Name of Clinician	Signature of Clinician	Date