CLIENT PSYCHOSOCIAL

Name:_____ Date:_____

CHIEF COMPLAINTS (please mark all that apply):

_____Abuse (physical, sexual, emotional)
_____Aggression, violence
_____Alcohol use
_____Anger, hostility, arguing
_____Anxiety, nervousness
_____Attention, concentration, distractibility
_____Career concerns, goals, choices
_____Childhood Issues
_____Children, child care, parenting
_____Codependence
_____Confusion
_____Compulsions
_____Custody of children
_____Decision making, indecision
_____Delusions (false ideas)
_____Dependence
_____Depression, sadness, crying
_____Divorce, separation
_____Drug use
_____Eating Problems
_____Emptiness
_____Failure
_____Fatigue, tiredness, low energy
_____Fears, phobias
_____Financial or money problems
_____Friendships
_____Gambling
_____Grieving, mourning, losses
_____Guilt
_____Headaches, other pain
_____Health, illness, medical concerns
_____Inferiority feelings
_____Interpersonal conflicts
_____Impulsiveness, outbursts
_____Irresponsibility
_____Judgement problems, risk taking
_____Legal matters, charges
_____Loneliness
_____Marital conflict, infidelity, remarriage
_____Memory Problems
_____Menstrual Problems, PMS, Menopause
_____Mood swings
_____Motivation, laziness
_____Nervousness
_____Nightmares
_____Obsessions, compulsions
_____Over sensitivity to rejection
_____Panic or anxiety attacks
_____Perfectionism
_____Pessimism
_____Procrastination, work inhibitions
_____Relationship Problems
_____School Problems
_____Self-centeredness
_____Self-esteem
_____Self-neglect, poor self-care
_____Sexual issues, dysfunctions, conflicts
_____Shyness, over sensitivity to criticism
_____Sleep problems (too much, too little)
_____Smoking, tobacco use
_____Stress, relaxation, tension
_____Suspiciousness
_____Suicidal thoughts
_____Temper problems, self-control
_____Thought disorganization and confusion
_____Threats, violence
_____Weight and diet issues
_____Withdrawal, isolating
_____Work problems, employment, workaholism

How long have these problems occurred? (number of weeks, months, years) _____

What happened that makes you seek help at this time? _____
_____
_____

Problems perceived to be: _____very serious _____serious _____not serious

A. Treatment:

Have you ever received psychological or psychiatric or counseling services before? ____NO

____YES If yes, When, For What, Describe Results: _____

_____

Have you ever taken medications for psychiatric or emotional problems? ____NO ____YES

If yes, When, From Whom, For What, Describe Results: _____

_____

_____

B. Relationships in your Family of Origin: Please describe the following:

1. Your parents' relationship with each other _____

   _____.

2. Your relationship with each parent: _____

   _____

   _____

3. Your parents' physical health problems, chemical use, and mental or emotional difficulties

   _____

   _____

4. Your relationship with your brothers and sisters, in the past and present _____

   _____

   _____

Abuse History:

_____I was not abused in any way. _____I was abused.

If you were abused, please indicate the type of abuse:

_____

_____

Present Relationships:

1. How do you get along with your present spouse or partner? _____

   _____

   _____

.

2. How many children do you have? _____

3. Names and ages: _____

4. How do you get along with your children? _____

_____

Do you have a social support system? Describe: _____

_____

_____

E. Chemical Use:

1. Have you ever felt the need to cut down on your drinking? _____NO _____YES
2. Have you ever felt annoyed by criticism of your drinking? _____NO _____YES
3. Have you ever felt guilty about your drinking? _____NO _____YES
4. Have you ever taken a morning "eye-opener?" _____NO _____YES
5. How much beer, wine, or hard liquor do you consume each week, on the average?

_____

_____

6. How much tobacco do you smoke or chew each week?

_____

7. Which drugs (not medications prescribed to you) have you used in the last 10 years?

_____

_____

F. Legal History:

Have you ever been arrested, placed on probation or parole in the past, or incarcerated?

_____

_____

G. Other:

Is there anything else that is important for me as your therapist to know about, and that you have not yet informed me about on any of these forms?

_____

_____

_____