

COMPLETE ALL INFORMATION PRIOR TO 2nd SESSION OR APPT WILL BE RESCHEDULED
PSYCHOSOCIAL HISTORY FORM
University Counseling Center

Name: _____ Date: _____

MEDICAL HISTORY

Date of last physical _____

Have you had any traumatic illness, injuries or physical abnormalities? _____ No _____ Yes

If yes, briefly explain: _____

How would you describe your general level of health? Excellent Good Fair Poor
 Are you currently under the care of a physician? _____ No _____ Yes If yes, briefly explain:

List any medications you are taking.

Medication	mg	Medication	mg
_____	_____	_____	_____
_____	_____	_____	_____

Who is the prescribing physician? _____

Do you eat a balanced diet? _____ No _____ Yes

Do you exercise regularly? _____ No _____ Yes

Do you have a family history of cancer, heart trouble, diabetes? _____ No _____ Yes

Have you ever experienced any on going problems:

- | | | | |
|--------------------|---------------------------|------------------------------|------------------------------|
| a.) fatigue | b.) loss of consciousness | c.) head traumas | d.) seizures |
| e.) dizziness | f.) headaches | g.) asthma | h.) musculoskeletal pain |
| i.) vision trouble | j.) fainting | k.) hives | l.) ulcers |
| m.) allergies | n.) hearing trouble | o.) nausea or vomiting | p.) abdominal pains |
| q.) bowel problems | r.) Dysmenorrhea | s.) Tachycardia—palpitations | t.) loss of feeling-tingling |
| u.) none | | | |

DRUG/ALCOHOL HISTORY

Which of the following have you used?

- | | | |
|---|---|--------------------------|
| a.) Acid (LSD) | b.) Methamphetamine (Crank) | c.) MOMA (Ecstasy) |
| d.) Steroids | e.) Inhalants (Gas, Paint, Airplane glue) | |
| f.) GHB (Gamma-hydroxybutyrate) | g.) Benzodiazepines (Xanax, Ativan, Valium) | |
| h.) Opioids (Codeine, Darvon, Vicodin, Dilaudid, Demerol, Heroin) | i.) Ritalin/Adderall | j.) Marijuana |
| k.) Quaaludes (Sedative/Hypnotics) | l.) Cough medicine | m.) Cocaine |
| o.) Barbiturates (Central Nervous System depressants "Downers") | n.) Hallucinogenics | p.) Tranquilizers |
| q.) PCP | r.) None | s.) Other: specify _____ |

How Often? _____

How often do you drink alcohol? (On average) _____

How often do you drink to the point of intoxication? _____ once or twice a year _____ once a month
 _____ once a week _____ several times a week _____ daily _____ never

Have you ever been involved in an alcoholism or drug treatment program? _____ No _____ Yes

Please Describe: _____

Did your parents or any family member have a problem with alcohol when you were a child?

_____ No _____ Yes

Do you smoke cigarettes? _____ No _____ Yes If yes, how frequently? _____

Do you use smokeless tobacco? _____ No _____ Yes. If yes, how frequently? _____

DEVELOPMENTAL/FAMILY/SOCIAL

When were you born? _____

How old were your parents when you were born? _____ Mother _____ Father _____

With whom did you live as a child? _____ Please list relationships and the ages during which you lived with them (ex: foster parents, grandparents, etc) _____

Was your family troubled by any of the following problems while you were growing up?

- a.) alcoholism b.) illness c.) poverty d.) mental illness e.) unemployment
- f.) trouble with the law g.) divorce h.) frequent moves i.) none

If so, briefly describe _____

How would you characterize your childhood? (Answer all that apply)

- a.) happy b.) frightening c.) unhappy d.) dull e.) hard to remember
- f.) secure g.) painful h.) regimented i.) uneventful

Which descriptions characterize your father (paternal care taker)

- a.) warm b.) distant c.) uncaring d.) domineering e.) unpleasant f.) overprotecting
- g.) rejecting h.) strict i.) abusive j.) fault finding k.) understanding l.) affectionate

Is he living? _____ If no, how old was he when he died? _____

How far did he go in school? _____ What is (was) his usual line of work? _____

How many times did he marry? _____

Which descriptions characterize your mother (maternal care taker)

- a.) warm b.) distant c.) uncaring d.) domineering e.) unpleasant f.) overprotecting
- g.) rejecting h.) strict i.) abusive j.) fault finding k.) understanding l.) affectionate

Is she living? _____ If no, how old was she when she died? _____

How far did she go in school? _____ What is (was) her usual line of work? _____

How many times did she marry? _____

How would you describe your parents (or parents substitutes) relationships with each other?

- a.) ideal b.) violent c.) indifferent d.) full of conflict e.) hot and cold f.) reserved
- g.) distant h.) happy i.) domineering/submissive j.) loving k.) hostile

What did your parents argue about?

- a.) money b.) discipline of children c.) relatives interfering d.) drinking e.) sex
- f.) jealousy g.) not taking care of home h.) not being a good provider i.) never argued

What are the ages and relationships (oldest to youngest) of your brothers and sisters?

NAME	AGE	RELATIONSHIP

Which descriptions characterize how you got along with your brothers and sisters as a child?

- a.) quarrelsome b.) distant c.) indifferent d.) close e.) other

How do you get along with your brothers and sisters now? _____

Rate your family's economic status during childhood and adolescence:

- a.) poverty level (received welfare) b.) working class c.) middle class
- d.) upper middle class e.) wealthy

What were your favorite activities during your childhood? _____

Which descriptions characterize you as a child? _____

- a.) outgoing b.) shy c.) active d.) awkward e.) irresponsible
- f.) nervous g.) rebellious h.) serious i.) stubborn j.) unhappy
- k.) calm l.) temperamental m.) self-confident

What were problems for you as a child?

- a.) getting along with mother b.) getting along with father c.) getting along with sibling(s)
- d.) getting along with peers e.) getting along with teachers f.) bed wetting
- g.) nightmares h.) excessive fears or worries i.) felt I was a burden to my parents
- j.) overweight k.) underweight l.) having my feelings hurt
- m.) fear of failure n.) none

Did you have intimate/close friends during childhood? _____ No _____ Yes

Do you have intimate/close friends now? _____ No _____ Yes

How would you describe your mother's discipline?

- a.) Strict b.) Fair c.) Lenient d.) Inconsistent

How would you describe your father's discipline?

- a.) Strict b.) Fair c.) Lenient d.) Inconsistent

How were you disciplined as a child?

- a.) Spanked b.) Grounded c.) Scolded d.) Wasn't disciplined e.) Other

Were you ever spanked or punished in a way that left marks on you? _____ No _____ Yes

Were you ever verbally abused as a child? (Example: told you were stupid, dumb or ugly?) _____

Have you ever been arrested or accused of a crime? _____ No _____ Yes If yes, explain _____

Did you ever run away from home? _____ No _____ Yes

What are the most vivid memories you have about your childhood? _____

At what age did you leave your childhood home and why? _____

CULTURAL BELIEFS

Do you consider yourself to be part of any cultural or ethnic group? (Example: Italian, Black, Indian)

_____ No _____ Yes If yes, briefly explain _____

Is there anything about your cultural beliefs of which you would like your therapists to be aware? _____ No

_____ Yes If yes, briefly explain _____

EDUCATIONAL HISTORY

Completed grades: 1 2 3 4 5 6 7 8 9 10 11 12

AA BA MA Ph.D. Technical School

How would you rate your intellectual ability?

_____below average _____above average _____average _____superior

Were you ever held back in school? _____No _____Yes

In general, what grades did you make in school? _____F's _____D's _____C's _____B's _____A's

Did you get in trouble at school? _____No _____Yes

Were you ever suspended from school? _____No _____Yes If yes, describe _____

Were you ever told you had learning disabilities or placed in a learning disability, special education, remedial or resource class? _____No _____Yes If yes, which one? _____

Did your peers ridicule, tease, or make fun of you more than other kids? _____No _____Yes

RELIGIOUS BELIEFS

Religious preference: _____

Is your religion or lack of religion a problem area in your life? _____ No _____ Yes
 Do the ways you were trained as a child sometimes cause you to feel guilty now?
 _____ No _____ Yes If yes, explain: _____

FINANCES

Family's primary source of income: _____ My earning _____ Relatives _____ Welfare
 _____ Spouse's earnings _____ Disability _____ Other
 Are you under any particular financial stress? _____ No _____ Yes If yes, briefly
 explain: _____
 Have you ever filed bankruptcy? _____ No _____ Yes

EMPLOYMENT HISTORY

_____ Employed _____ Unemployed _____ Retired _____ Disabled _____ Never employed
 Name of company _____ Job title _____
 Company address _____ Phone _____
 Length of employment _____ Hours _____ Week _____ Salary _____

Are you satisfied with your present job? _____ No _____ Yes
 If no, briefly explain: _____
 Briefly describe job duties: _____
 What type of jobs have you performed in the past? _____
 Length of longest job? _____
 Have you ever been fired or laid of? _____ No _____ Yes If yes, describe _____

CHILDREN

Do you have children? _____ No _____ Yes If yes, are any of these children by a previous marriage? Please
 indicate by placing H for husband's and a W for wife's next to the name of the child.

Name	Sex/Age	DOB	School/Grade
Living in the home			
_____	_____	_____	_____

Do your children have any special problems? _____ No _____ Yes
 _____ Behavioral _____ Emotional
 _____ Physical _____ School
 If yes, which child and briefly explain _____

Have you or your spouse ever had an abortion, miscarriage, or stillbirth? _____ No _____ Yes
 If yes, briefly explain: _____
 Have you or your spouse ever been accused of child abuse? _____ No _____ Yes
 If yes, briefly explain: _____

RECREATIONAL/LEISURE

What do you do for fun? _____
 If finding a way to enjoy these activities hard for you? _____ No _____ Yes If yes, briefly
 explain: _____
 Do you belong to any clubs, groups, or organizations? _____ No _____ Yes
 Names: _____

Are there any activities you want to be involved in but don't know how? _____ No _____ Yes
If yes, briefly explain _____

SEXUAL HISTORY

Briefly describe your parent's attitude toward sex _____
At what age did you begin dating? _____ At what age did you become sexually active
with petting? _____ With intercourse? _____
Have you ever had any traumatic sexual experience? (Such as sexual molestation, rape, etc.)
_____ No _____ Yes If yes, briefly explain: _____
Is your present sex life satisfactory? _____ No _____ Yes If no, briefly
explain: _____
History of pornography use? _____ No _____ Yes. If yes at what age did you begin viewing pornography? _____
How often do you view pornography? _____

MARITAL HISTORY

_____ Single, but involved in intimate relationship _____ Single _____ Married
_____ Divorced _____ Separated _____ Widowed
Have you ever been divorced? _____ No _____ Yes If yes, how many times and what were the
reasons? _____
Length of present marriage _____ Age when married _____ Spouse's age _____
Do you and your spouse differ in attitudes on any of the following?
a.) sexual matters b.) leisure activities c.) religion d.) finances
e.) use of alcohol or drugs f.) women's role in the family g.) raising children h.) infidelity
i.) men's role in family j.) other _____ k.) spouse's occupation _____
Have you ever been physically, verbally, or sexually abused by your spouse?
_____ No _____ Yes If yes, briefly explain: _____

SELF ESTEEM

Please complete the following sentences:

I am a person who _____
All my life _____
Ever since I was a child _____
One of the things I feel proud of is _____
It's hard for me to admit _____
One of the things I can't forgive is _____
If I didn't have to worry about my image _____
One of the ways people hurt me is _____
My mother is _____
My father is _____
What I needed from my mother and didn't get is _____
What I needed from my father and didn't get is _____
If I weren't afraid to be myself, I might _____
One of the things I'm angry about is _____
The bad thing about growing up is _____
Is there anything about yourself you would like to change? _____ No _____ Yes
If yes, briefly explain: _____
How would you rate your ability to cope with life? _____ Very Good _____ Good _____ Fair _____ Poor

How would you describe yourself (Circle ALL that apply):

- | | | | | |
|--------------------|------------------------------|--------------------|--------------------|------------------|
| a.) Quiet | b.) Outgoing | c.) Talkative | d.) Shy | e.) Active |
| f.) Aggressive | g.) Temperamental | h.) Self-confident | i.) Wild Care-free | j.) Stubborn |
| k.) Easygoing | l.) Friendly | m.) Smart | n.) Impatient | o.) Responsible |
| p.) Rebellious | q.) Serious | r.) Unassertive | s.) Worthless | t.) Useless |
| u.) A nobody | v.) Life is Empty | w.) Inadequate | x.) Stupid | y.) Incompetent |
| z.) Naïve | aa.) Can't do anything right | bb.) Guilty | cc.) Evil | |
| dd.) Morally wrong | ee.) Horrible Thoughts | ff.) Hostile | gg.) Full of Hate | hh.) Anxious |
| ii.) Agitated | jj.) Cowardly | kk.) Panicky | ll.) Ugly | mm.) Deformed |
| nn.) Unattractive | oo.) Repulsive | pp.) Depressed | qq.) Lonely | rr.) Unloved |
| ss.) Misunderstood | tt.) Bored | uu.) Restless | vv.) Confused | ww.) Unconfident |
| xx.) In Conflict | yy.) Full of regrets | zz.) Worthwhile | a.) Sympathetic | b.) Intelligent |
| c.) Attractive | d.) Considerate | | | |

MILITARY HISTORY

If you have ever been in the military, circle the branch that applies:

USA, USN, USCG, USMC, USAF, USPHS Length of service _____

Highest rank _____ Why did you enlist? _____

APR or OER Ratings: _____ Most Recent _____

Job Title: _____ Briefly describe job duties _____

Have you ever received any disciplinary action including LOC, LOR, Article 15, Court Martial?

Circle all that apply and briefly explain: _____

Type of discharge: _____ Are you eligible for VA benefits? _____ No _____ Yes

CURRENT STRESSORS

Do you feel you are under any particular stress? Such as school, family, marital, financial, relationship, legal, or job stress? _____ No _____ Yes. If yes, briefly describe: _____

OBJECTIVE

Age _____ Height _____ Weight _____ Hair Color _____ Eye Color _____

NEUROVEGATIVE SIGNS

Do you ever hear voices or feel people are out to get you? _____ No _____ Yes

If yes, briefly explain: _____

Do you have a problem with any of the following? (Circle ALL that apply):

- | | | | |
|------------------------------------|----------------------------|-------------------------------------|---------------------|
| a.) Loss of interest in sex | b.) Suicidal attempts | c.) Loss of control | d.) Weight increase |
| e.) Decreased energy level | f.) Increased energy level | g.) Guilt | h.) Fatigue |
| i.) Promiscuity | j.) Accidental proneness | k.) Gambling or compulsive spending | |
| l.) Change in eating habits | m.) Weight loss | n.) Lack of concentration | o.) Nightmares |
| p.) Past/present suicidal thoughts | | | |

If yes to any of the above, briefly explain: _____

PAST MENTAL HEALTH CARE AND STATUS

Instructions: Please check the boxes that apply

1. I have seen a mental health therapist or counselor before

If you checked the box above,

A. Name _____

Date: _____

Reason _____

B. Name _____

Date: _____

C. Name _____

Date _____

Reason _____

3. I have previously taken medication for a psychological problem.

If you checked the box above indicate when and what the medications are.

4. I have been hospitalized for psychological problems.

5. My previous treatment was

- partially helpful
- temporarily helpful
- unhelpful
- no previous treatment

6. I have been satisfied with all of my prior mental health care.

7. I have had sleeping difficulties in the past:

from ____/____/____ to ____/____/____
related to _____

from ____/____/____ to ____/____/____
related to _____

from ____/____/____ to ____/____/____
related to _____

8. I have felt depressed or especially sad and blue in the past:

from ____/____/____ to ____/____/____
related to _____

from ____/____/____ to ____/____/____
related to _____

from ____/____/____ to ____/____/____
related to _____

9. I have felt especially anxious or tense in the past:

from ____/____/____ to ____/____/____
related to _____

from ____/____/____ to ____/____/____
related to _____

from ____/____/____ to ____/____/____
related to _____

CURRENT MENTAL HEALTH CARE AND STATUS

Instructions: Please check the boxes that apply

1. I am currently seeing a therapist

If you checked the box above, please provide the therapists name.

The reasons I am currently seeking therapy are _____

2. I am currently taking medication for a psychological problem

If you checked the box above, please indicate what medications you take and how often. _____

3. My moods at the present time are:

- Happy, cheerful, optimistic
- Relaxed, calm, peaceful
- Neutral, bland, apathetic
- Controlled, un-revealing
- Worried, anxious, fearful
- Sad, tearful, pessimistic
- Sarcastic, irritable, angry
- Mood swings, changes in mood
- Other _____

4. The total number of hours per day or night that I usually sleep _____

5. Recently, I have had sleeping difficulties

- Never, once, or twice
- Occasionally but not frequently
- Frequently
- Almost continuously

6. Difficulties with my sleeping pattern are

- | | Began about |
|--|-------------|
| <input type="checkbox"/> Insomnia, difficulty falling asleep | ____/____ |
| <input type="checkbox"/> Frequent waking during the night | ____/____ |
| <input type="checkbox"/> Decreased hours of sleep | ____/____ |
| <input type="checkbox"/> Restlessness, tossing or turning | ____/____ |
| <input type="checkbox"/> Early morning waking | ____/____ |
| <input type="checkbox"/> Increased hours, sleeping more | ____/____ |
| <input type="checkbox"/> Nightmares or night terrors | ____/____ |
| <input type="checkbox"/> Trouble getting up in the morning | ____/____ |
| <input type="checkbox"/> Other _____ | ____/____ |
| <input type="checkbox"/> None | |

7. Recently, I have felt depressed or especially sad or blue.

- Never, once, or twice
- Occasionally but not frequently
- Frequently
- Almost continuously

8. When depressed or sad, I experience

- | | Began about |
|---|-------------|
| <input type="checkbox"/> Crying episodes, tearfulness | ____/____ |
| <input type="checkbox"/> Poor appetite | ____/____ |
| <input type="checkbox"/> Decreased interest in activities | ____/____ |
| <input type="checkbox"/> Decreased interest in people | ____/____ |
| <input type="checkbox"/> Decreased interest in sex | ____/____ |
| <input type="checkbox"/> Feelings of guilt | ____/____ |
| <input type="checkbox"/> Decrease in physical energy | ____/____ |
| <input type="checkbox"/> Sleep related problems | ____/____ |
| <input type="checkbox"/> Weight loss or gain | ____/____ |
| <input type="checkbox"/> Irritability, anger | ____/____ |
| <input type="checkbox"/> Other _____ | ____/____ |

9. Recently, I have felt especially anxious or tense.

- Never, once, or twice
- Occasionally but not frequently
- Frequently
- Almost continuously

- No distress _____/____
- Mild distress _____/____
- Moderate distress _____/____
- Severe distress _____/____
- Extreme distress _____/____
- Disabling distress _____/____

16. What I would most like to change about myself is _____

17. I have been referred or ordered to receive psychological treatment

10. When anxious or tense I experience

- | | | |
|--|-------------|-----------|
| <input type="checkbox"/> Pacing, restlessness, agitation | Began about | ____/____ |
| <input type="checkbox"/> Shortness of breath | | ____/____ |
| <input type="checkbox"/> Chest pain or heart pounding | | ____/____ |
| <input type="checkbox"/> Dizziness or fainting | | ____/____ |
| <input type="checkbox"/> Sweating | | ____/____ |
| <input type="checkbox"/> Numbness or tingling in hands or feet | | ____/____ |
| <input type="checkbox"/> Muscle aches or cramps | | ____/____ |
| <input type="checkbox"/> Cold hands | | ____/____ |
| <input type="checkbox"/> Stomach or intestinal symptoms | | ____/____ |
| <input type="checkbox"/> Dry mouth | | ____/____ |
| <input type="checkbox"/> Other _____ | | ____/____ |

18. My current motivation for treatment

- Highly motivated
- Reasonably motivated
- Poorly motivated
- Unmotivated

19. The barriers to my treatment are

- Attitudes toward therapy
- Family interference or work interference
- Health problems
- Financial or transportation problems
- Other _____

11. Overall, mental or emotional problems now cause me

- | | | |
|---|-------------|-----------|
| <input type="checkbox"/> No distress | Began about | ____/____ |
| <input type="checkbox"/> Mild distress | | ____/____ |
| <input type="checkbox"/> Moderate distress | | ____/____ |
| <input type="checkbox"/> Severe distress | | ____/____ |
| <input type="checkbox"/> Extreme distress | | ____/____ |
| <input type="checkbox"/> Disabling distress | | ____/____ |

20. Indicate which of the actions, feelings, or thoughts below have been present, bothersome, or distressing within the recent past. Draw a line through any part of an item that is not accurate. Indicate about when the feeling or experience began.

- Difficulty making decisions, difficulty deciding what to do. Fear of mistakes or failure, difficulty dealing with things as well as I would like.

Began about ____/____

- Bad habits, continue to do something I know could cause a problem, act too quickly, do not think things through like I should.

Began about ____/____

- Feeling driven or almost out of control, strong urge to take a risk or to get a need met, gamble, drive fast, shoplift, or to be with someone.

12. I have had a psychologically traumatic experience.

If you checked the box above please indicate when and briefly identify _____

13. The psychological problem that causes me the most concern currently is _____

14. This problem began about ____/____

15. This problem causes me _____
 Began about _____

- Began about ____/____
- Feelings easily hurt, others don't seem to understand me, regret, shame, guilt; feel like I am not a "good" person; like I deserve to be punished.
Began about ____/____
- Difficulty controlling my mind, feel like my mind is being controlled, loss of control, feelings of unreality, unusual or troubling thoughts.
Began about ____/____
- Language problems such as not being able to remember words, loss of consciousness, loss of memory, amnesia.
Began about ____/____
- Repetitive thoughts, difficulty not thinking about something or someone.
Began about ____/____
- Repetitive behavior such as washing, touching, checking, arranging, or counting, nervous habits such as tapping, hand-wringing, finger rubbing.
Began about ____/____
- Anxiety, worry, apprehension, panic, become terrified or very frightened, intense or irrational fears
Began about ____/____
- Suicidal thoughts, impulse to hurt myself, want to die, thoughts that I would rather be dead than alive.
Began about ____/____
- Not enough friends, loneliness, few people like me or care about me, no one to talk things over with, difficulty getting along, arguing, conflict, irritable with friends.
Began about ____/____
- Shyness, self-conscious, uncomfortable when people watch me, uncomfortable with the opposite sex.
Began about ____/____
- Uneasy or nervous in crowds, open places, buses, or when left alone.
Began about ____/____
- Fearful about myself or others, like something bad is going to happen, premonitions, feelings of dread or foreboding. Began about ____/____
- Difficulty trusting others that I know or that I don't know, feel I need to be on guard. Began about ____/____
- Not getting the credit I deserve for what I have accomplished, unfairly treated, being taken advantage of.
Began about ____/____
- Irritability, anger, rage, angry thoughts, or feelings, feel like I want to hurt someone, smash or break things.
Began about ____/____
- Mood swings, emotional roller coaster, feeling ups and downs, moods come "out of nowhere" or sweep over me.
Began about ____/____
- Hot, cold flashes, sweating, chills that are not related to air temperature, vision or balance problems, perceptual distortions, hearing, smelling, seeing, or feeling things that are not real.
Began about ____/____
- Someone has indicated to me that they think I may have some psychological problem or difficulty about which I am not aware or about which I do not agree.
Began about ____/____