SOCIAL HISTORY (child/adolescent)

Name: ____ Age:_______ Sex: _______

DEVELOPMENTAL/ FAMILY HISTORY:

Where were you born? ____

How many brothers?____How many sisters? _____Where do you fall in birth order? _________

Were your parents together while you were growing up? …………………...Yes ☐ No ☐

How old were you when your parents separated? ____

Who raised you?____

Were there stepparents or significant others living in the home?………………Yes ☐ No ☐

What was the relationship like between you and your family members? ____________________

____

Was anything unusual about your early developmental years? (walking, talking, etc.)
Yes ☐ No ☐ If so, explain ____

____

Were you ever the victim of physical abuse? Yes ☐ No ☐ Sexual abuse? Yes ☐ No ☐

Were you ever the victim of emotional abuse? …………………………………. Yes ☐ No ☐

Were there any other traumatic experiences in your early life?…………………. Yes ☐ No ☐

If so, explain ____

How did your caretakers discipline you?____

____

Was it effective? ………………………………………………………………… Yes ☐ No ☐

Did you ever witness violence in your home? …………………………….....…Yes ☐ No ☐

Notes:

ACADEMIC FUNCTIONING:

What grade are you in?____

How would you describe your grades? Below Average ☐ Average ☐ Above Average ☐

Are you attending school? ……………………………………………………..…Yes ☐ No ☐
If not, why?____

Were you ever held back any years, or placed in any special classes or programs? Yes ☐ No ☐
If so, explain____

____

Did you have behavioral problems in the school setting? (i.e. fights, suspensions, referrals, etc?)
Yes ☐ No ☐ If so, explain.____

____

____

How many fights did you get in during your school years? _______________________

Was it easy for you to make friends during your school years? ……………......Yes ☐ No ☐

Were you involved in any clubs, sports, or other out of school structured activities? Yes☐ No☐
Explain: ____

____

Did you ever run away from home? ……………………………………………...Yes ☐ No ☐

How was your behavior at home during your school years?_______________________

____

Were there any unusual or traumatic events which occurred during this period of your life?
Yes ☐ No ☐ Explain: ____

____

CURRENT CIRCUMSTANCES:

With whom do you currently live? _____________________________________

Notes:

List the names, age and relationship of all individuals living in the household________________
____
____

Do you have any strong religious affiliations? ………………………………….. Yes ☐ No ☐

Are you involved in any clubs, organizations, gangs, etc? ……..……………... Yes ☐ No ☐

Do you spend most of your time ……………………………..with other people ☐ or alone? ☐

Is it difficult for you to make friends? ……………………………………….... Yes ☐ No ☐

Do you maintain friendships for long periods of time? ………………………..Yes ☐ No ☐

Have any of your friendships ended in anger or violence? ………………………Yes ☐ No ☐

What types of activities do you typically engage in with friends?___________________________
____

What is the age range of most of your friends? … … …… Same age ☐ Older ☐ Younger ☐

Do you believe you have difficulties with your temper (anger)? ……………….. Yes ☐ No ☐

Would others agree with your opinion on this issue? ……………………………Yes ☐ No ☐

What types of things make you angry? ____

When you get angry how do you handle it? ____
____

Do you own or have access to any weapons? …………..………………………Yes ☐ No ☐

Where are they? ____
____

DRUGS AND ALCOHOL:

How often and how much do you drink? ____

What is the most you have drunk on any one occasion? __________________________________

Notes:

When was the last time you drank alcohol? ______________________________

List all drugs that you use and indicate the frequency and quantity of all use: ______________
____
____

When was the last time you used any illegal drugs? ______________________________

Have you ever noticed that you needed increased amounts of drugs or alcohol to achieve the same high? ……………………………………………………………………Yes ☐ No ☐

Have you noticed drugs and alcohol having less of an effect on you if you continue to use the same amount? …………………………………………………………………Yes ☐ No ☐

If you refrain from drugs and alcohol or are unable to obtain them, do you experience any withdrawal symptoms? ………………………………………………………...Yes ☐ No ☐

Have you ever used drugs and alcohol in larger amounts or over a longer period of time than was intended? ……………………………………………………………………Yes ☐ No ☐

Do you experience cravings or persistent desire for drugs or alcohol? ………..Yes ☐ No ☐

Have your efforts to cut down or control your drug or alcohol use been unsuccessful? …………………………………………………………………..Yes ☐ No ☐

Do you spend a great deal of time in activities necessary to obtain drugs and alcohol? …………………………………………………………………......Yes ☐ No ☐

Have you ever given up activities or involvements because of your use of drugs and alcohol? ….……………………………………………………………………Yes ☐ No ☐

Have you continued usin drugs and alcohol despite knowing that it is causing problems for you? ……………………………………………………………………..Yes ☐ No ☐

How old were you the first time you used alcohol? ________ Illegal drugs? ____________

List all street drugs that you have used in the past: ______________________________
____

Describe your consumption of drugs and alcohol at the point in your life when you were using the heaviest: ____

Notes:

How old were you during this period in your life? ____

Have you ever received any drug or alcohol related arrests? ……………………Yes ☐ No ☐

Have you ever experienced any substance-induced blackouts? …………………Yes ☐ No ☐

Have you ever been treated in a drug or alcohol facility? ………………………..Yes ☐ No ☐

MEDICAL HISTORY:

Briefly describe all current medical conditions: ____
____
____

List all medications and dosages (including over-the-counter) that you are currently taking: ____
____
____
____

List any head injuries or surgeries:____
____
____

PSYCHIATRIC HISTORY:

How old were you the first time you received any counseling or psychiatric care? _____________

List all treatment (inpatient and outpatient) in chronological order along with the reason for the treatment and whether the treatment was helpful. ____
____
____
____

What conditions were you diagnosed as suffering from: ___________________________________
____
____

Have you ever taken medications for emotional or psychiatric conditions? ……..Yes ☐ No ☐

Notes:

List any medications that you have taken in the past, and your current medication and dosage.
Past:
____

Present: ____

Is there a history of mental illness in your family (biological relatives)? ………..Yes ☐ No ☐

LEGAL HISTORY:

List all criminal charges, the disposition of the case and any time served (include arrests as a juvenile) ____
____
____
____

Do you currently have any charges pending against you? ………………………Yes ☐ No ☐

Describe all civil lawsuits that you have been involved in? ____________________________
____

OCCUPATIONAL FUNCTIONING:

Have you ever had a job? ………………………………………………………...Yes ☐ No ☐

What is the longest period of time spent on one job? __________________________________

Why did you leave that position? ____

Have you ever been fired from a job? …………………………………………....Yes ☐ No ☐

Why? ____
____
____

Have you had behavioral difficulties in the job setting such as getting along with bosses and co-workers? ………………………………………………………………………..Yes ☐ No ☐

Where are you currently employed? ____

Notes:

How long have you been in this position? ____

ANGER MANAGEMENT:

How often do you get angry (daily, weekly, etc)? _____________________________________

How long do you stay angry toward someone? ____

When you are angry is your behavior a problem? …………..……………………..Yes ☐ No ☐

Do you ever throw things or hit things when you are angry? …...……………….Yes ☐ No ☐

Do you yell and scream when you are angry? ……………………………….... Yes ☐ No ☐

What do you do to calm yourself down when you are angry? ____________________________
____

Have you ever felt so angry that you thought intentionally hurting or killing someone else? ……………………………………………………………………………Yes ☐ No ☐

If yes, please describe: ____
____
____

Notes:

Community Behavioral Services

Problem Checklist

Name:____Date:__________________Age:________

Place a check mark by any of the following difficulties that you have experienced during ***the past 6 month***

- ❑ Depressed mood.
- ❑ Periods of excessive sadness.
- ❑ Mood swings.
- ❑ Periods of feeling too good, or too energetic.
- ❑ Loss of energy.
- ❑ Too much energy.
- ❑ Times you are feeling so good, high, or excited, that other people thought that you were not your normal self or that you got into trouble.
- ❑ Periods when you were so irritable that you found yourself shouting at people, starting fights, or arguments.
- ❑ Increased need for sleep.
- ❑ Decreased need for sleep.
- ❑ Difficulties in attention or concentration/ being easily distracted.
- ❑ Racing thoughts.
- ❑ Increased agitation or irritability.
- ❑ Feeling anxious or nervous a great deal of the time.
- ❑ Feeling scared a lot of the time.
- ❑ Phobias or fears which have interfered in your ability to live a normal life.
- ❑ Periods of panic.
- ❑ Pain for which there is no physical cause.
- ❑ Physical difficulties for which your physician reports there is no cause.
- ❑ Excessive worry or stress.
- ❑ Sleep disturbance.
- ❑ Nightmares.
- ❑ Loss of job.
- ❑ Difficulties in your relationships with people.
- ❑ Periods of isolation.
- ❑ Academic or learning difficulties.
- ❑ Behavioral problems at home or at school.
- ❑ Hyperactivity/ impulsively.
- ❑ Stealing, lying, hurting others.
- ❑ Actions or behaviors that you feel compelled to do, over and over again, that you have been unable to resist doing.
- ❑ Any behavior you have been unable to control or stop.
- ❑ Uncontrollable urges to commit inappropriate acts such as stealing, setting fires, fighting, etc.
- ❑ Low self-esteem.
- ❑ Failure to comply with recommended medical or psychological treatment.
- ❑ Abuse or neglect of a child.
- ❑ Domestic violence.
- ❑ Abuse or neglect of an elderly person.
- ❑ Marital difficulties.
- ❑ A serious loss or trauma.
- ❑ Problems with alcohol use.
- ❑ Problems with drug use.
- ❑ Appetite disturbances.

- ❑ Excessive weight loss.
- ❑ Inability to maintain your normal weight.
- ❑ The use of purging or medications to control your weight.
- ❑ Decreased sexual desire.
- ❑ Difficulty in sexual performance.
- ❑ Unusual or disturbing sexual interests or fantasies.
- ❑ Memory loss.
- ❑ Blackouts.
- ❑ Periods of time which are unaccounted for, or you cannot recall what happened.
- ❑ Being bothered by unpleasant thoughts that do not make sense and keep coming back even when you try ro control them.
- ❑ Reliving past traumatic experiences through nightmares or flashbacks.
- ❑ Weighing less than others thought you should.
- ❑ Being excessively afraid of becoming fat.
- ❑ Periods of binge eating (eating excessive amounts of food in short periods of time.)
- ❑ Being afraid of being around people.
- ❑ Missing school or work because of drug or alcohol use.
- ❑ A feeling that people are taking a special notice of you.
- ❑ Receiving special messages from television, newspaper, or other unusual means.
- ❑ Feeling that people are trying to hurt you or give you a hard time.
- ❑ Feeling that either you or other people have special powers.
- ❑ Feeling that someone or something outside of yourself is controlling your thoughts or actions.
- ❑ Having thoughts that were not your own or were being put into your head.
- ❑ Seeing things that other people could not see.
- ❑ Having strange sensations in your body or skin.
- ❑ Smelling things that other people could not smell.
- ❑ Hearing voices that other people could not hear.
- ❑ Outburst of anger or violence.
- ❑ Being forewarned/ known that something would happen before it did.
- ❑ Feeling of hopelessness.
- ❑ Things happened which have special meanings only for you.
- ❑ Being in a place and having no recall of how you got there.
- ❑ Greeted by people who call you by another name and seem to know you.
- ❑ Feeling detached or separated from yourself.
- ❑ Being so involved in a daydream you couldn't tell if it was real or not.
- ❑ Thoughts of suicide.
- ❑ Thoughts of killing others.
- ❑ Bizarre or unusual experiences that you cannot explain.
- ❑ Visions.
- ❑ Head injury.
- ❑ Being arrested.
- ❑ Medical problems.
- ❑ Other: ________________________________

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