Community Behavioral Services- Joni Neidigh, MA, LMHC, CCH

Social History Form

CLIENT NAME:________________________________ **DOB:**__________________

Presenting Problem:____

Email:_____________________ **Contact Phone #:**__________________

DEVELOPMENTAL/FAMILY HISTORY:

Where were you born?____

Do you have any brothers? #_____ Sisters?#_____ Where do you fall in the birth order?______

Was there anything unusual about your early developmental years? (Walking, talking, etc.).. Yes☐ No☐
Were you every a victim of physical abuse? Yes☐ No☐
Were you ever the victim of sexual abuse? Yes☐ No☐
Were you ever the victim of emotional abuse? Yes☐ No☐
Were there any traumatic experiences early in your life? Yes☐ No☐
If so, please explain____
Did you ever witness violence in your home? Yes☐ No☐

ACADEMIC AND SOCIAL INFORMATION:

How far did you go in school?______________________

Did you drop out of school? Yes☐ No☐
Were you ever held back any years, or placed in any special classes or programs? Yes☐ No☐
Did you have any behavioral problems in the school setting (fights, suspensions, etc.)? Yes☐ No☐
Was it easy for you to make friends during your school years? Yes☐ No☐
Did you maintain friendships for long periods of time? Yes☐ No☐
How did you spend most of your time? With others ☐ Alone ☐
Were you involved in any clubs, sports or other out of school structured activities? Yes☐ No☐
Did you ever run away from home? Yes☐ No☐
Were you ever arrested during your school years? Yes☐ No☐
Did you use any drugs or alcohol during your school years? Yes☐ No☐

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

Were there any unusual or traumatic events, which occurred during this period in your life? Yes☐ No☐

OCCUPATIONAL FUNCTIONING

Where are you currently employed?______________________________________

How long have you been in this position?______________________________

Have you ever had periods of unemployment lasting longer than a few weeks? Yes☐ No☐
Have you had any difficulties maintaining steady employment? Yes☐ No☐

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

Have you ever been fired from a job? Yes☐ No☐
Have you had any behavioral difficulties in the job setting such as getting along with bosses or co-workers? Yes☐ No☐

Have you ever been in the military? Yes☐ No☐ –If yes, please answer the following questions....

Branch and length of service?____

Were there any disciplinary actions against you while in the military? Yes☐ No☐

What type of charge did you receive?______________________________________

Do you have a service-connected disability? Yes☐ No☐ Explain:________________________

Have you ever failed to meet any of your financial obligations, such as loans, child support bills, etc? Yes☐ No☐

RELATIONSHIP INFORMATION:

With whom do you currently live?____

What is your sexual orientation?____

Have you ever been married? Yes☐ No☐ How long?_______________ How many times?__________

How long has you most serious relationship lasted?______________________________________

Are you currently involved in a serious relationship? Yes☐ No☐
Was there any domestic violence during the course of your relationships? Yes☐ No☐
Do you have children or stepchildren? Yes☐ No☐
How would you describe your relationship with your children? Good ☐ Fair ☐ Poor ☐
How do you discipline your children? ____

____

Have you ever been accused of abusing or neglecting any child? Yes☐ No☐
Do you have any religious affiliations? Yes☐ No☐
Are you currently involved in any clubs, organizations, hobbies? Yes☐ No☐

Friendships:
Do you have a best friend? Yes☐ No☐
How do you spend most of your time? With others ☐ Alone ☐
Is it difficult for you to make friends? Yes☐ No☐
Are you anxious around new people or large crowds? Yes☐ No☐
Do you maintain friendships for long periods of time? Yes☐ No☐
Have any friendships ended in anger or violence? Yes☐ No☐

How would your friends describe your personality?_____________________________________

DRUGS AND ALCOHOL:

How often do you consume alcohol and how much do you drink on each occasion?________________

____

List all drugs that you used and indicate the frequency and quantity of all used (do not include over the counter and prescribed medications): ____________________

____

What is the most you have drank on one occasion?____________________

When was the last time you drank alcohol?____________________

When was the last time that you used any illegal drugs?____________________

Have you noticed that you needed increased amounts of drugs or alcohol to achieve the same high?
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 that 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 or alcohol? Yes☐ No☐
Have you ever given up on activities or involvements because of your use of drugs and alcohol? Yes☐ No☐
Have you continued using drugs and alcohol despite knowing that it is causing problems for you?
Yes☐ No☐
How old were you the first time you used alcohol?____________________

How old were you the first time you used illegal drugs?____________________

List all street drugs 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: ____________________

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 for drug or alcohol problems? Yes☐ No☐

If yes, please describe:____________________

____

MEDICAL HISTORY

List and describe all medical conditions you are currently being treated for: ____________________

____

____

List all medications and dosage (including over the counter) that you are currently taking: ____________________

____

____

____

List any head injuries or surgeries that you have had: ______

______

______

PSYCHIATRIC HISTORY:

Have you eve received counseling or psychiatric care? Yes☐ No☐

When?______

Where?______

By Whom?______

What conditions were you diagnosed as suffering from?______

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

If yes, list any medications that you have taken:______

______

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

If so, please provide details:______

LEGAL HISTORY:

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

______

______

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

Describe all civil lawsuits that you have been involved in:______

______

ANGER MANAGEMENT/SELF CONTROL:

Do you believe you have difficulties with your anger?

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?______

What types of things make you angry?______

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

Do you yell or scream when you are angry? Yes☐ No☐

What do you do to calm yourself when you are angry?______

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

If yes, then please describe:______

Do other people inform you that your anger is a problem? Yes☐ No☐

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

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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