Psychosocial History

Name: ________________________________ DOB: _________________ Today's date:

____

FAMILY HISTORY

Is your father living? ____________ Father's age: __________ Where does your father live?

____

Father's occupation: ___________________________ Father's values growing up:

____

Describe your relationship with your father

now: ____

What was it like growing up?

____

Is your mother living? ___________ Mother's age: _________ Where does your mother live?

____

Mother's occupation: __________________________Mother's values growing up:

____

Describe your relationship with your mother now:

____

What was it like growing up?

____

Describe your parents' relationship with each other (when you were a

child):_________________________________

What is it like now?

____

Do/did you have step-parents? ___________ Describe your relationship: ____________________________

____

List the names and ages of your brothers and sisters:

____

____

Are you the oldest ☐ youngest ☐ middle ☐ ?

Are/were there major cultural or religious influences in your family? Describe:

____

____

Describe your family growing

up:____

____

Describe your childhood:

____

Describe your current religious or spiritual beliefs/practices:

____

How has substance use affected your religious or spiritual beliefs/practices?

____

Number of marriages/partners:________Marital/partner status:______________ How

long?________

Children (names and

ages):____

Which children are living with you?

____

How has your use of alcohol/drugs affected your family

relationships?________________________________

Are any of your family members alcoholics or chemically dependent? (answer below)

	Yes	No		Yes	No
Mother			Aunts/Uncles		
Father			Grandparents		
Siblings			Children		
Step Parents			Spouse/partner		

How did the family you grew up in affect who you are today?

____

____

SEXUAL HISTORY

How did you learn about

sex?____

How old were you when you began dating?_________ What did you do on

dates?_________________________

Describe your first sexual experience:____ Were you

using? ________

How has alcohol/substance use affected your sex life?

____

Were you ever sexually abused?

____

Describe any current sexual concerns:

____

EDUCATION/MILITARY HISTORY

Growing up what was school like for

you?____

Highest grade completed:________________ Current employment

status:________________________________

What has been your major field of employment (trade,

profession)?____

Military history (branch, rank, length of service, discharge type, disciplinary proceedings):

____

____

LEGAL HISTORY
Arrest history: dates and reasons:

____

____

Describe any current legal issues, including probation:

____

SOCIAL HISTORY
Where/with whom do you currently live?

____

What do you do in your spare

time?____

Who do you turn to for

support?____

What percentage of your friends drink/use drugs?

____

Have they ever commented on your drinking/drug use?

____

EMOTIONAL HISTORY
Have you ever been in counseling?_______________ List the names of past

therapists:____________________________

Answer accordingly for the past year:	never	rarely	sometimes	often	regularly
I have difficulty sleeping					
I have difficulty eating well or with appetite					
I have difficulty concentrating					
I feel down or depressed					

If so, what was helpful?________________________ What was not helpful?
____

How has your alcohol/drug use affected your emotional

life?____

Have you experienced abuse or trauma?
____

SUBSTANCE USE HISTORY

Have you ever

tried to cut down on your drinking/drug use? ☐yes ☐no

been annoyed by others commenting about your drinking/drug use? ☐yes ☐no

felt guilty about your drinking/drug use? ☐yes ☐no

	Age 1st used	Date last used	Amount	Frequency	Circumstances of use	Currently using?
Alcohol						
Marijuana						
Cocaine						
Stimulants						
Tranquilizers						
Heroin						
Pain medication						
Hallucinogens						
Steroids						
Nicotine						
Caffeine						
Other						

Treatment history for drinking/drug use (below)

Names of treatment facilities/providers	______________________	______________________	_____________
Dates of treatment	______________________	______________________	______________
Outcomes	______________________	______________________	______________

drank/used to eliminate a hangover? ☐**yes** ☐**no**

Describe your patterns of alcohol/drug use over your lifetime, and note any changes in patterns:

____

____

Is there anything more you want to share?

____

____

Client Signature: ____________________________________ Date: ____

Therapist Signature: _________________________________ Date: ____

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ASSESSMENT