FAMILY PSYCHOLOGY ASSOCIATES, P.C.

Medical and Social History Form

This is not a test - just a way for your counselor to get to know you.
We understand that you may feel uncomfortable about divulging personal information.
If you are uncomfortable about any question on this form, talk to your counselor about it.

Name: _____ **Today's Date:** _____
Address: _____
Date of Birth: _____ **Age:** _____ **Race:** _____ **(optional)**

FAMILY INFORMATION:

Current Living Situation:
Marital status: []Never Married []Cohabitating []Married []Separated []Divorced []Widowed
If not living alone, with whom are you now living? _____

_____

If Married
Spouse=s Name: _____ Date of Birth _____ Date of Marriage _____
If this is not your first marriage, note the dates of previous marriage(s) and the name(s) of your previous spouse(s) _____

_____

Describe your spouse=s (or companion=s) personality _____

_____

Is your present relationship satisfactory? If not, specify what is unsatisfactory _____

_____

Names and ages of your children: _____

_____

Do you have special concerns about any of your children? Is so, explain _____

_____

Family of Origin:
Names, ages and marital status of your parents _____

_____

Names and ages of brothers _____
Names and ages of sisters _____
Describe your family life as you were growing up _____

_____

PERSONAL INFORMATION:

Educational level achieved: Self _____ Spouse _____
If you are currently a student list name of school and full or part-time status _____

_____

What is your current job? _____
How long have you held your current job? _____
What other types of work have you done? _____

_____

If employment problems are part of your reason for seeking counseling, specify _____

_____

Religion: Self _____ Spouse _____

Please complete form on reverse side.

HEALTH INFORMATION:

Physician:_____

Have you sought counseling previously? If so, who did you see, why and when? _____

_____

Was that counseling satisfactory? Why or why not? _____

_____

What is your current reason for seeking counseling? _____

_____

Do you have any major medical problems? If so, please describe _____

_____

_____

Have you ever had a major head injury? _____

Do you ever lose control of your anger? If so, explain _____

_____

_____

Have you, or a family member, ever been hospitalized for emotional problems? Is so, please explain when, where and why _____

_____

_____

Are you currently taking any medications? If so, please state which ones, dosage and how long you have been on them _____

_____

Do you have any allergies: If so, are you currently taking medications for allergies?_____

_____

Have you ever become dependent on any doctor prescribed medications? If so, explain _____

_____

_____

ALCOHOL AND DRUG USE:

Have you ever felt you ought to cut down on your drinking? _____

Have people annoyed you by criticizing your drinking? _____

Have you ever felt bad or guilty about your drinking? _____

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye opener)? _____

How much alcohol do you consume in a week? _____

Have you ever used any illegal drugs? If so, which ones and how often? _____

_____

_____

Has drinking or drug use caused you problems with the law or at work? If so, explain _____

_____

_____

Have you ever sought treatment for substance abuse? If so, describe when and where and what effect it had on your use _____

_____

Has anyone in your family had problems with substance use or treatment for substance use? If so, explain _____

_____

Thank you for filling out this form. Your answers will be kept confidential.