ADULT SOCIAL HISTORY QUESTIONNAIRE

Name____

Birth date____________________ Age____________________________

Date____________________________

LIST FAMILY MEMBERS BY NAME	AGE	SEX	EDUCATION	OCCUPATION	IF DECEASED CAUSE/AGE
MOTHER					
FATHER					
STEPMOTHER					
STEPFATHER					
BROTHERS/SISTERS					
IF MARRIED, NAME(S) OF SPOUSE(S)					
DATES OF MARRIAGES AND SEPARATIONS/DIVORCES					
CHILDREN					
PRIMARY RESIDENCE/ADDRESS					

DEVELOPMENTAL HISTORY QUESTIONNAIRE

1. What are the main difficulties and problems for which you are seeking help?
____
____
____
____
____
____

2. Any serious illnesses experienced currently or in the past?
Yes____ No_____
State age ______________/ and nature of illness:
____
____
____
____
____
____
____

3. Have you received previous counseling for emotional or behavioral problems? Yes_____ No_____ If Yes, Please list Providers and Dates:
____
____
____
____
____

4. Are you currently experiencing any health problems (including allergies)?
Yes_____ No_____ If Yes, Please list::
____
____
____
____
____

DEVELOPMENTAL HISTORY QUESTIONNAIRE

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5. What medication do you take? Name and Dosage:
____
____
____
____
____
____

6. In the past, have you received medications for behavioral or emotional problems?
____
____
____
____

7. Have you ever been hospitalized, in residential treatment, foster care, emergency shelter or correctional program? Yes____ No____
If Yes, Please list Programs and Dates:
____
____
____
____
____
____

8 Have you ever used Alcohol or Drugs? Yes_____ No_____ If Yes, please explain:
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____
____
____
____
____

DEVELOPMENTAL HISTORY QUESTIONNAIRE

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10. Has anyone in your family had a problem with Alcohol/Drugs in the past or Now? Check below and comment:

YES	NO	DON'T KNOW	COMMENTS:
			FATHER
			MOTHER
			STEPFATHER
			STEPMOTHER
			BROTHER OR SISTER
			GRANDPARENTS
			OTHER RELATIVES
			OTHERS

11. Have you experienced any of the following?:

YES	NO	DON'T KNOW	IF YES, WHAT AGE	AGE	COMMENTS
			DEATH OF PARENT		
			DEATH OF A CLOSE RELATIVE		
			DEATH OF SPOUSE		
			DEATH OF CHILD		
			PARENTAL SEPARATION OR DIVORCE(S)		
			ACCIDENT OR SERIOUS INJURY		
			HOSPITALIZATION OR SURGERY		
			SEPARATION OR DIVORCE FROM SPOUSE		
			PHYSICAL ABUSE		
			SEXUAL ABUSE		
			WITNESSED VIOLENCE TOWARDS FAMILY MEMBERS		
			OTHER HIGHLY STRESSFUL OR TRAUMATIC EXPERIENCES		

			OTHER/ PEASE LIST:		

DEVELOPMENTAL HISTORY

12. Additional Comments or Concerns:

____
____
____
____
____
____
____

13. Please place an "X" by any of the items listed below that identify your strengths:

A. Coping Resources:

___Good Worker – thorough
___Patient
___Tolerant
___Learns from experience
___Makes good decisions,
___Athletic
___Healthy
___Physically strong
___Coordinated
___Courageous
___Responsible
___Honest, generally
___Creative

___Enthusiastic
___Adaptable
___Flexible
___Not easily upset
___Cheerful/Optimistic
___Follows directions
___Dependable, generally
___Persistent/Determined
___Assertive
___Independent
___Average or (+) intelligence
___Good memory

B. Social Skills and Support:

___Liked by others

___Close relationships with, one or more adults

___Cooperative

___Outgoing

___Caring

___Talkative

___Confides and seeks support from family member

___Can compromise and share

___Nurturing towards young children

___Helpful, Supportive

___Accepts comfort and guidance

___Expresses feelings and problems

___Respects others

___Confides and seeks support from one or more friends

___Active in community

C. Self-Esteem:

___Likes self

___Self-forgiving, doesn't dwell on mistakes

___Cares about the future

___Feels capable

___Confident

___ Cares about appearance

___Recognizes own strengths and skills

D. OTHER STRENGTHS:

____

____

____

____

____

____

____

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____

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____

DEVELOPMENTAL HISTORY PAGE 7

Goals for Personal Improvement

If you would like to change some of these habits check the ones that you would like your counselor to help you overcome.

- ___________ drinking alcoholic beverages too much
- ___________ smoking too much
- ___________ eating too much
- ___________ exercising too little
- ___________ feeling too much attraction to members of my own sex
- ___________ feeling too much attraction to members of the opposite sex
- ___________ thinking depressing thoughts
- ___________ feeling anxious in crowds
- ___________ worrying about my health
- ___________ stuttering
- ___________ washing my hands too often
- ___________ cleaning and straightening things up too often
- ___________ biting my fingernails
- ___________ being careless of my physical appearance
- ___________ being too afraid of pain
- ___________ being too afraid of blood
- ___________ feeling anxious about contamination or germs
- ___________ feeling anxious about being alone
- ___________ thinking the same thoughts over and over
- ___________ counting my heartbeats
- ___________ hearing voices
- ___________ feeling people are against me or out to get me
- ___________ seeing visions or objects that aren't really there
- ___________ wetting the bed at night
- ___________ taking too much medicine
- ___________ having too many headaches
- ___________ gambling
- ___________ being unable to fall asleep at night
- ___________ exposing my body to strangers
- ___________ desire to be hurt or humiliated
- ___________ stealing
- ___________ lying
- ___________ yelling at people when I am angry
- ___________ hitting people when I am angry
- ___________ poor management of money
- ___________ saying "crazy" things to other people
- ___________ having difficulty carrying on a conversation with other people
- ___________ bothering or irritating people
- ___________ forgetfulness
- ___________ contemplating suicide
- ___________ setting fires
- ___________ difficulty being steadily employed
- ___________ being uncomfortable at work
- ___________ swearing
- ___________ being upset when criticized by others
- ___________ failing to express by feelings

DEVELOPMENTAL HISTORY PAGE 8

Goals for Personal Improvement – continued

___________ putting things off that need to be done

___________ thoughts that make me feel guilty

___________ feeling anxious about sexual thoughts

___________ having difficulty making decisions when have to be made

___________ feeling uncomfortable with people in a group

___________ playing computer games too much

___________ looking at pornography (magazines, websites, movies, etc.)

___________ feeling anxious about …

____

___________ feeling depressed about …

____

___________ feeling guilty about …

____

___________ being unable to control my desire to …

____

Please add anything that you feel might help us understand your concerns:

____

____

____