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Psychosocial History

Name: _____ Date:_____ SS:_____-_____-_____

Birth date_____ Sex_____ Address_____

Phone #_____ In your own words, why did you come here? _____

_____

_____

How do you feel about being here? _____

_____

A. Marital history spouse refers to husband, wife, girlfriend, or boyfriend)
   1. Marital status (circle the word that best explains your status)
      single engaged married separated divorced widowed divorced/remarried
   2. If you have been married, how many times? _____
   3. How old were you when you were first married? _____
   4. How many years have you been married to your present spouse? _____
   5. How old is your present spouse? _____

B. Educational history (please circle)
   1. Grade school
   2. High school 1 yr. 2 yrs. 3 yrs. 4 yrs. GED
   3. College 1 yr. 2 yrs. 3 yrs. 4yrs. Postgraduate
   4. Have you ever been in special education classes? _____ yes _____ no if so, why were you in
      these classes? _____
   5. Have you ever had tutoring? _____ yes _____ no if so, what for? _____

C. Drinking and Drug history relative to school
   1. Are you still I school? _____ yes ____ no Name of the school _____
   2. Has your drinking or drug ever caused problems in school? _____
   3. Have you ever been sent home from school because of drinking or drug use? __ yes__ no
   4. Have you ever been suspended from school? _____ yes _____ no
   5. Have you ever been expelled from school? _____yes _____ no if so, why were you expelled explain: _____
   6. Are you in danger of being expelled now? ____ yes ____ no if so, please explain: _____
      _____
   7. Have the school authorities suggested that you come here? _____ yes _____ no if they have, please explain: _____
   8. Are you having other school problems? ____ yes ____ no if so, please explain:_____

9. Do you have enough credits to graduate? _____ yes _____ no if not, please explain:_____

D. Military history

1. Have you ever been in the armed forces? _____ yes ____ no if yes, which branch? _____
2. What was rating and rand? _____
3. How long were you in the service? _____
4. Date you enlisted _____ Date you entered service _____
5. Current status _____ Type of discharge _____

E. Employment history

1. Are you employed? _____ How long? _____
2. Name of the employer _____
3. Job title _____ Gross annual income _____
4. What is your occupation? _____
5. How long have you done this type of work? _____
6. What type of work would you like to do, even though you may not have the necessary training or skills? _____

Employment history (list most recent jobs first)

Job Title	Date Started	Date Finished	Reason for Leaving
a.			
b.			
c.			

8. Describe any problems on the job (past or present) _____

10. Do you have medical insurance? _____

10. Do you have public aid? _____ yes _____ no

F. Family history

1. Are parents still leaving together? _____ yes _____ no
2. If your parents are separated or divorce, whom do you live with? ____ mother _____ father
3. Describe your father: _____
4. Describe your mother: _____
5. List your brothers and sisters, and circle any stepbrothers or stepsisters.

a._____

b._____

c._____

d._____

e._____

f._____

6. Where were you in order of birth (oldest to youngest)? _____
7. Which brother or sister are you the close to? _____

please explain: _____

8. Which brother or sister are you least close to? _____

please explain: _____

9. Which person in your family makes the decisions? _____

please explain: _____

11. If you need to borrow money, which member of the family would you ask? _____

_____

12. Did you eat dinner with your family? ____ yes ____ no _____

How many nights a week? _____

Please explain: _____

13. Do you believe in God? _____ yes _____ no What denomination_____

14. Do you go to church regularly? _____

15. Do you have a girlfriend/boyfriend? _____ yes _____ no

16. Do the two of you spend a lot of time together? _____yes _____ no

17. Would you say that your boyfriend/girlfriend has a drinking problem? _____ yes _____ no

    Please explain: _____

18. Did anyone in your family suffer from the following (underline)? Nervous breakdown; fits or convulsions; nervousness; migraine headaches; visions; stuttering; times when they could not remember what they were doing; times when they acted strangely or peculiarly; alcohol problem; drug abuse.
    If you have underline any of the choices above, state which family member and when and how affected._____

19. Did you ever belong to a gang? _____ yes _____ no

20. What teams or clubs did you belong to as a child? _____

    List those in which you were an officer: _____

21. What do you do outside of work or school (hobbies, leisure)? _____
    _____

22. About how many close friends do you have? _____
    Describe them by name, sex, and age: _____

    Has any of them ever had a drinking or drug problem? _____ yes _____no If so, please

    Describe: _____

    _____

23. List your children, and circle those who are adopted or by a previous marriage.

a. _____

b._____

d. _____ _ _____

e._____

G. Legal history

1. Do you have any arrest charges pending? _____ yes _____ no If so, what are they? _____

Charge	Court Date	Location
a._____		
b._____		
c._____		
d._____		

2.have you had previous arrest? _____ yes _____no

If so, what were the charges and when were they filed

Charge Date

a._____

b._____

c._____

d._____

3. Are you on probation? _____ yes _____no

On parole? _____yes _____ no

Under court supervision? _____yes _____ no

4. Have you attended or are you attending a class on alcohol or drug safety?

_____ yes _____no

If so, where? _____

5. Were you referred to treatment by the class? _____yes _____no

6. Were you referred to treatment by the Social Services Department or the Circuit Court?

7. Were you ordered to treatment by the Circuit Court? _____ yes _____ no

If so, what county? _____

Who was the judge? _____

8. Do you have a lawyer or public defender? _____ yes _____ no

Which? _____

9. Were you referred to treatment by your lawyer? _____ yes _____ no

If so, what is your lawyer's name? _____

Phone no . _____

10. Would you consent to sing a release of information allowing us to communicate with any of the above agencies or authorities on specific treatment issues? _____ yes _____no

11. What day is your court date? _____

12. If not listen above, who referred you? _____

H. History of the drinking, other drug use, and treatment (check all items that apply to you, or give the information requested; if not applicable, mark N/A)

1. Have you ever been treated for an alcohol problem before? _____ yes _____ no
   If yes, complete the following:

   a. Detoxification only_____ How many times? _____ Places and dates: _____

   Did you finish treatment? _____ yes _____ no If no, please explain: _____

   b. Rehabilitation _____ How many times? _____ Places and dates:

   Did you finish treatment? _____ yes _____ no If no, please explain_____

   c. Outpatient therapy _____ How many times? _____ Places and dates:

   Did you finish treatment? _____ yes _____no If no, please explain _____

   d. Would you consent to sign a release of confidential information allowing us to commu-

nicate with any of these programs on specific treatments issues? _____ yes _____ no

2. Have you ever been involved with Alcoholics Anonymous? _____ yes _____ no If so, how

   Often did/do you attend meetings? _____

   Were they open or close? _____

   Did/do you have a sponsor? _____ yes _____ no

3. At what age did you first drink? _____ Describe the circumstances and consequences: __

   _____

4. At what age did you first lose control of your drinking? _____ (I have never lost control

   of my drinking; I just drink daily.)_____

5. At what age did you have your first blackout? _____ (I have ner had blackouts.) _____
6. At what age did your blackouts begin to increase? _____
7. When and why did you first become concerned about your drinking? _____

   _____

8. What is the average amount of hard liquor you consume? (check one)

_____none _____ about 1 pint a day _____ very little

_____about 1 quart a day _____occasional "benders" _____ more than 1 quart a day

_____ a couple of "shots" a day _____ other _____

9. What is the average number of beers you consume? (check one)

_____ none _____ very few _____ several a day _____ occasional "benders"

_____ about 5 to 10 a day _____ more than 20 a day _____ other_____

10. What is the average amount of wine you consume? (check one)

_____ none _____ very little _____ occasional "benders" _____ about 1 pint a day

_____ about 1 quart a day _____ about 2 to 4 quarts a day _____ more than 4 quarts a day

11. Do you ever go on "binges" (periods of uncontrolled drinking)?

_____ yes ____ no _____ once a year _____ every 1 to 3 months _____ every weekend

_____ every 3 to 6 months _____ every 6 to 8 months _____ other _____

12. Do you drink daily? _____ yes _____ no

How long have you been drinking daily? (check one)

_____ just this last month _____ 1 to 3 months _____ 3 to 6 months _____ 6 to 9 months

_____ 1 year _____ 2 years _____ longer than 2 years _____ How long? _____

13. Do you notice that you have the "shakes" when you stop drinking? _____ yes _____ no

If so, when did this first happen? _____

Please describe: _____

Have you ever seen or heard things that were not actually there? _____ yes _____ no

If so, when? _____

Have you ever had delirium tremens (DTs)? _____ yes _____ no

If so, when? _____

Please describe: _____

_____

Have you ever had a seizure? _____ yes _____ no If so, when?_____

Please describe: _____

14. Has physician ever told you to stop drinking? _____ yes _____ no If so, why? _____

_____

_____

15. With whom do you usually drink? (check as many as apply)

_____ spouse _____other relatives _____neighbors

_____ people at work _____ friends at a bar _____ strangers

_____ "buddies" on the street _____ by myself _____ kids at school

16. When drinking, how do you act?

_____ seldom get angry or violent _____ get in to physical fights

_____ get mean or surly _____ get happy

_____ get into angry arguments _____ have fun

Other _____

17. How do your parents, wife/girlfriend or husband/boyfriend feel about your drinking?

_____ don't seem to mind _____ nag me about it

_____ don't say much about it _____ question doesn't apply

_____ threatened to leave because of my drinking

18. Have your family activities changed because of your drinking? _____ yes _____ no

19. Has your sexual life changed because of your drinking? _____ yes _____ no

20. Have you ever quit drinking? _____ yes _____ no

How long did you stay sober? _____

When was the last time (date)? _____

Did this dry period follow from of treatment? _____ yes _____ no If so, what type and Where? _____

What things do you do to stay sober? _____

Did you have any symptoms when you stopped drinking? _____

21. Have you ever used cough syrup or other medicines containing alcohol as substitutes for liquor of for the purpose of getting high? _____ yes _____ no

_____ prescription _____ non-prescription

Have you used any other alcohol substitutes? _____ yes _____ no If so, please Identify: _____

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22. What moot-altering drugs have you taken? (check as many as apply)

Prescribed by Physician

_____ tranquilizers (Valium, Librium Miltown, etc.) _____ yes _____ no
Type_____
_____ psychotropics (Stelazine, Cogentin, Thorazine, etc.) _____ yes _____ no
Type_____
_____ barniturates (Quaaludes, phenobarbital, Nembutal, Tuinal, Seconal) _____ yes _____ no
Type_____
_____ amphetamines (Dexedrine, Benzedrine, Methedrine, etc.) _____ yes _____ no
Type _____
_____ sleeping pills _____ yes _____ no
Type_____
_____opiates (heroin, morphine, opium,etc.) _____ yes _____ no
Type_____
_____ pain killers (Darvon, codeine etc.) _____ yes _____ no
Type_____
_____ hallucinogens (LSD, STP, MDA, PCP, mescaline, etc.) _____ yes _____ no
Type_____

_____ cocaine. If so, how often? _____

_____ marijuana. If so, how often? _____

_____ glue sniffing. If so, how often? _____

23. Have you ever received treatment for a drug problem? _____yes _____ no
If so, what type of treatment? _____

_____

Where? _____

When? _____

24. Have you ever been involved with Narcotics Anonymous? _____ yes _____ no
If so, how often you attend meetings? _____
Were they open or closed? _____
Do you have a sponsor? _____ yes _____ no

25. When do you usually drink of use drugs? (check as many as apply)

_____ weekends _____ occasionally during the da y

_____after work or evenings _____ frequent, short "benders"

_____ regularly during the day _____ most of the time

_____ long, occasional"benders"

26. Which apply to you? (check as many as apply)

_____ I am losing control of my drinking/drug use. _____ I have a drinking problem.

_____ I'm an alcoholic/drug addict. _____ My tolerance is decreasing.

_____ I can't stop myself. _____ I need a drink when I wake up.

_____ I am deteriorating rapidly. _____ I'm not eating regularly.

_____ I know why I drink/use drugs. _____ I'm strictly a social drinker.

_____ I hate myself. _____ My tolerance is increasing

_____ I can quit any time. _____ I get arrested because of my drinking or drugging.

_____ I might be an alcoholic/drug addict. _____ I have been unable to complete a task (or

_____ I have accidents or fall while drinking begin a task) because I was drinking

And sometimes injure myself. _____ I have a drug problem.

_____ I'm a problem drinking/drug user but nor an addict.

27. Which of these apply to you at this time?

_____ school problems _____ financial problems

_____ marital problems _____ treat to job

_____ physical problems _____ loss of job

_____ family problems _____ legal problems

_____ loneliness other_____

28. What do you expect from treatment?

_____

_____

What might we expect from you? _____

_____

29. In your words, what is alcoholism/drug dependence? _____

_____

30. Is alcoholism/drug dependence disease, or is it a bad habit? _____

_____

31. Have you ever been treated for emotional/psychiatric problems? _____ yes _____ no

If so, complete the following.

How many times? _____

Where? _____ When? _____

Where? _____ When? _____

Where? _____ When? _____

Have you ever attempted or considered attempting suicide?

_____ yes _____ no

How many times, and when? _____

_____

32. Describe yourself : _____

_____

_____

33. What are you weaknesses? _____

_____

What are your strengths? _____

_____

34. Are you interested in further treatment or help, and do you know what is available? _____

35. Please add any information that you feel could be important to your treatment: _____

_____

36. Do you have any questions? _____

_____

37. Next of Kin _____

Address _____

Client signature _____ Date: _____

Staff signature _____ Date _____

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