Dr. Linda Lee
Creative Holistic Counseling

Confidential Psychosocial History - Adult

Date: _____ How did you hear about my practice: _____

Name: _____ Age: _____
Last First Middle

Email: _____ SSN: _____ Date of Birth: _____

Address: _____
Number and Street City State Zip

Phone: Cell: _____ Can a message be left: ☐ Yes ☐ No
Home: _____ Can a message be left: ☐ Yes ☐ No
Work: _____ Can a message be left: ☐ Yes ☐ No

May I use text messages or email for appointment reminders? Text: ☐ Yes ☐ No Email: ☐ Yes ☐ No

Emergency Contact: _____
Name Telephone Relationship

Relationship Information:

Current Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Live w/Partner ☐ Widow

Name of Spouse/Significant Other: _____ Length of Relationship: _____

Previous Marriages/Relationships and Durations:

1) _____
2) _____
3) _____

Names and Ages of Children: How would you rate the relationship (Excellent/Good/Fair/Poor/No Contact)

1) _____
2) _____
3) _____
4) _____

Any Additional Family Information: _____

_____

Family of Origin History:

Birth Location: _____ Religion: _____

Race: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Other: _____

Frequency of Moving: _____

Raised by: ☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Other: _____

Relationship with Parent Figures: (Excellent/Good/Fair/Poor/No Contact/Deceased

Mother: _____ Father: _____ Other: _____

Names and Ages of Siblings: How would you rate the relationship (Excellent/Good/Fair/Poor/No Contact)

1) _____
2) _____
3) _____
4) _____

Any Additional Family Information: _____

_____

_____

_____

Education History:

Did you walk, talk, and read on time? ☐ Yes ☐ No Did your mother experience birth complications with you? ☐ Yes ☐ No Please explain: _____

_____

_____

Any repeated grades? ☐ No ☐ Yes: Which grades: _____

Any Special Education classes? ☐ No ☐ Yes: Which classes: _____

Highest grade completed: _____ Education/Training beyond high school: _____

Highest Degree: _____ Any Additional Education Information: _____

Employment History:

Are you currently employed? ☐ Yes ☐ No Your Occupation: _____

Employer: _____ How Long: _____

Job Satisfaction: ☐ Excellent ☐ Good ☐ Fair ☐ Poor What could improve? _____

_____

Any Additional Employment Information: _____

_____

Medical History:

Self-Assessment of Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current Physician: _____ Practice Location: _____

Other Health Care Providers: _____

May I contact your physician(s) as part of your treatment planning and coordination? ☐ Yes ☐ No

Major Medical Problems: _____

_____

Medications and Dosages: _____

_____

_____

Any serious injuries or hospitalizations: ☐ Yes ☐ No If Yes, please explain: _____

_____

Any head injuries? ☐ Yes ☐ No If Yes, please explain: _____

_____

Allergies: ☐ Yes ☐ No Please list: _____

Any Additional Health Information: _____

_____

Mental Health History:

Have you received mental health services before: ☐ Yes ☐ No If Yes, with whom, when, and for how long?

_____

_____

Diagnosis? _____

Psychiatric Hospitalizations? ☐ Yes ☐ No How many? ____ Dates: _____

Past Suicidal Ideation? ☐ Yes ☐ No Current Suicidal Ideation? ☐ Yes ☐ No

Past Homicidal Ideation? ☐ Yes ☐ No Current Homicidal Ideation? ☐ Yes ☐ No

Please describe any history of neglect and/or physical, verbal, emotional, spiritual, sexual or other abuse:

_____

_____

Please describe any family history of traumatic experiences? (war, accident, health condition, fire, disaster, etc.)

_____

Any Additional Mental Health Information (include medications): _____

_____

_____

Substance Use History:

Check all that apply: ☐ Alcohol ☐ Caffeine ☐ Tobacco ☐ Marijuana ☐ Other: _____

Substance abuse treatment? ☐ Yes ☐ No Please provide dates, program name, and length of programs:

_____

_____

Any other substance use/abuse history, including family history: _____

_____

Legal History:

Any arrests or incarcerations? ☐ Yes ☐ No Any pending legal issues? ☐ Yes ☐ No

Military History:

Any military history? ☐ Yes ☐ No If Yes, please describe: _____

_____

Lifestyle:

Describe your actual exercise program: _____

_____

Describe your eating habits, food preferences, and allergies: _____

_____

Do you have a bowel movement once or more every day? ☐ Yes ☐ No

Describe your typical work day: _____

_____

Describe your typical non-work day: _____

_____

Describe your sleep habits and pattern: _____

_____

Do you have enough energy to do the things you enjoy? ☐ Yes ☐ No

Have you practiced meditation? ☐ Yes ☐ No Do you have a regular meditation practice? ☐ Yes ☐ No

What time of day is your best? _____ Your worst? _____

What season do you feel your best? _____ How often to you get out in nature? _____

Describe your home and neighborhood environment: _____

_____

Describe your ideal lifestyle: _____

_____

Tell me anything else that is important for me to know about you: _____

_____(use back if needed) ____