Therapy for Children, Adults and Families, Inc.
821 Raymond Ave., Suite 330
St. Paul, MN 55114
651-697-9981

Social History

Name: _____ Date _____

Birthdate: _____ Age:_____

Occupation:_____ Employer: _____

Relationship status: _____

I. Family: Please list immediate family members and other significant individuals.

Name		Age	Yrs of Education or highest degree	Occupation	Lives in the home? Yes/no
Spouse / partner –					
Son / daughter					
Son / daughter					
Son / daughter					
Brother / sister					
Brother / sister					
Brother / sister					
Parent					
Parent					
Other					

a. Have there been major upsets or significant changes in family life or family structure (birth, death, divorce, adoption, foster placement, recent move, etc.)? Explain:

_____

b. Are there other significant people in your life? (friends, co-workers, church members, other relatives, etc.)? Explain:

_____

c. How do members of the family get along? Explain:

II. Medical: please list all medical conditions that you have been diagnosed with and when:

_____

a. Any hospitalizations? When and why?

_____

b. Are there any genetic conditions or illnesses that have affected your health and development? Explain:

_____

c. Past and present medication use (when, reason prescribed, dosage, side effects, etc.)

_____

d. Who is your medical doctor?

_____

e. Do any members of the family have major illnesses or chronic health problems? Explain:

_____

III. Educational

a. What level of education have you completed? _____

b. College major? _____

c. Did you experience any learning or adjustment problems at any level of school (pre-school, primary, elementary, middle, high school, college, graduate school)? Explain

_____

IV. Social: Please describe any life impacting events that have occurred in your life. Please indicate the date or estimated time period for each.

_____

V. Family: Any family members with a history of the following conditions?
Anxiety, Depression, Bi-Polar Disorder, Substance Abuse, Trauma, Schizophrenia. If yes; who, what diagnosis, when and treatment received.

_____

VI. Mental and Emotional Health

1. How would you describe your mental and emotional health at this time?
   Poor Fair Good Very Good Excellent

2. Have you ever received therapy or counseling? Yes/No.
   If yes, please list dates, reasons, therapist(s):

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3. Are you currently (or in the past) taking medications? Yes/No
   If yes, please list medications, dosage and dates:

_____

4. Current stressors in your life:

_____

5. Have you ever had suicidal thoughts, plans or attempts? Yes/No If yes, when and why?

_____

6. Current presenting problem(s): _____

_____

VII. SUBSTANCE ABUSE

1. Do you consume alcoholic beverages? Yes/No. If yes, How often? _____

2. How much alcohol do you usually consume when drinking? _____

3. Has anyone ever expressed concern about your alcohol and/or drug use? Yes/No If yes, who and why?

_____

4. Have you ever been to AA/NA, drug/alcohol rehab or therapy for addiction or substance use? Yes/No If yes, explain:

_____

VII. Other Relevant Information: Please use this space to provide any other information that you think may be relevant to your current issues and why you are pursuing help at this time:

_____