

# Keys to Living Counseling Center

## **Psychosocial History**

Client Name \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Therapist \_\_\_\_\_

**To be completed by therapist**

***Duty to Warn Explained***

**YES NO**

***Mandatory Reporting Explained***

**YES NO**

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### **Family/Relationship History**

Marital status: Married\_\_ Separated\_\_ Divorced\_\_ Single\_\_ Widowed\_\_ Partnered\_\_

Previous marriages: Self Yes\_\_ No\_\_ Date married\_\_\_\_ Date divorced\_\_\_\_  
Spouse Yes\_\_ No\_\_ Date married\_\_\_\_ Date divorced\_\_\_\_

Children from previous marriages: (Circle those living in home)

Self: sex/age\_\_\_\_\_

Spouse: sex/age: \_\_\_\_\_

Children from present marriage : (Circle those living in home)

Name

Sex

Age

Adopted/Biological

Brothers and sisters: (Circle any problematic relationships)

M F Age M F Age M F Age M F Age M F Age M F Age M F Age M F Age

Any major health problems, alcohol/drug abuse, other addictive behaviors or mental health issues in your family:

Parents divorced? Y N Your age when divorced?\_\_\_\_ Parents living? Father Y N Mother Y N  
Parents a current problem? Y N

### **Work/Education:**

Highest level of education \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Length of employment: \_\_\_\_\_

Problems related to career/vocation? \_\_\_\_\_

Military involvement present/past? \_\_\_\_\_

### **Nutrition/Exercise:**

Currently on a special diet? Yes\_\_ No\_\_ Describe: \_\_\_\_\_

Balanced diet including fruits and vegetables? Yes\_\_ No\_\_

Intake of highly sweetened and/or caffeinated drinks? Amount/day \_\_\_\_\_

Exercise? \_\_\_\_\_

Recreation/hobbies? \_\_\_\_\_

**Spirituality:**

Desire to pursue counseling from a Christian perspective? Yes \_\_\_ No \_\_\_  
Desire for prayer to open or close therapy session? Yes \_\_\_ No \_\_\_  
Church affiliation: \_\_\_\_\_ Attendance: \_\_\_\_\_

Importance of own faith/spirituality? \_\_\_\_\_  
Regularity of devotional/quiet time/meditation time? \_\_\_\_\_  
Current spiritual/religious issues needing help with? \_\_\_\_\_

**Medical History:**

Current prescribed medications/dosage: \_\_\_\_\_  
Prescribing physician: \_\_\_\_\_  
Past hospitalizations, surgeries, medical issues \_\_\_\_\_  
Current medical issues: \_\_\_\_\_  
Allergies: \_\_\_\_\_ None known \_\_\_\_\_

Ongoing physical pain? Yes \_\_\_ No \_\_\_ Frequency? \_\_\_\_\_ Location? \_\_\_\_\_  
When began? \_\_\_\_\_ Intensity (0 none -10 extreme) \_\_\_\_\_  
Physical disabilities or limitations of movement, sight, or hearing? Yes \_\_\_ No \_\_\_  
If yes, explain \_\_\_\_\_

**Abuse:**

History of being sexually abused? Yes \_\_\_ No \_\_\_ History of being physically abused? Yes \_\_\_ No \_\_\_  
If yes, state relationship to the abuser. \_\_\_\_\_ Date(s) of abuse \_\_\_\_\_  
Was the abuse reported? Yes \_\_\_ No \_\_\_ If yes, to whom? \_\_\_\_\_  
Any abuse of any kind to other members of family? Yes \_\_\_ No \_\_\_ If yes, to whom? \_\_\_\_\_

**Psych Treatment History:**

Outpatient: Yes ___ No ___			
Therapist or agency	Dates From/To	Problem/Area of Concern	
_____	_____	_____	_____
_____	_____	_____	_____

Inpatient: History of hospitalizations/treatment: ie, emotional problems, drug/alcohol treatment: Y \_\_\_ N \_\_\_  
Date(s): \_\_\_\_\_  
Reason(s): \_\_\_\_\_

**Risk:**

Family history of suicide: Yes \_\_\_ No \_\_\_ Attempts? Yes \_\_\_ No \_\_\_  
Personal history of suicidal thoughts: Yes \_\_\_ No \_\_\_ Attempts? Yes \_\_\_ No \_\_\_ When attempted: \_\_\_\_\_  
How/Method: \_\_\_\_\_  
Current suicidal thoughts: Yes \_\_\_ No \_\_\_ Plan \_\_\_\_\_  
Thoughts of harming another person: Yes \_\_\_ No \_\_\_ If yes, explain \_\_\_\_\_

**Substance use/abuse/addictions:**

Tobacco use: Yes \_\_\_ No \_\_\_ Frequency: \_\_\_\_\_ Quantity: \_\_\_\_\_  
Alcohol use: Yes \_\_\_ No \_\_\_ Frequency \_\_\_\_\_ Quantity \_\_\_\_\_ Problem? Yes \_\_\_ No \_\_\_  
Drug use: Yes \_\_\_ No \_\_\_ Frequency \_\_\_\_\_ Quantity \_\_\_\_\_ type \_\_\_\_\_ Problem? Yes \_\_\_ No \_\_\_

Arrests for being under the influence of alcohol/drugs? Yes \_\_\_ No \_\_\_ # \_\_\_\_\_  
Have you ever quit drinking or quit using drugs? Yes \_\_\_ No \_\_\_ # \_\_\_\_\_  
Use of drugs (pot, speed, cocaine, etc.) or misuse of prescription drugs in past year? Yes \_\_\_ No \_\_\_  
Describe: \_\_\_\_\_

Gambling: Yes \_\_\_ No \_\_\_ Describe \_\_\_\_\_  
Pornography: Yes \_\_\_ No \_\_\_ Describe \_\_\_\_\_  
Other addictions: \_\_\_\_\_

**Legal:**

History of legal convictions: \_\_\_\_\_

Reason: \_\_\_\_\_

Incarcerations: jail: \_\_\_\_\_ prison: \_\_\_\_\_

Currently involved with the court or legal system? Y N Past/present involvement with DHS? Y N Describe:

\_\_\_\_\_  
\_\_\_\_\_

**Finances:**

Problems relating to finances. Describe:

\_\_\_\_\_  
\_\_\_\_\_

**Symptoms**

Please check all of the following that apply – place a question mark by those you are unsure of:

**Depression**

- Suicide ideation/attempts
- Depressed/sad
- Discouraged
- Low energy
- Low motivation
- Appetite change
- Weight loss/gain
- Sleep problems
- Loss of enjoyment
- Loss of concentration
- Increased emotions
- Irritability
- Agitation
- Worthlessness
- Hopelessness
- Helplessness
- Difficulty coping

**Anxiety**

- Worry
- Headaches
- Stomach upset
- Dizziness
- Tired/fatigued
- Tense/nervous
- Chest tightness
- Poor sleep
- Irritable
- Trembling

**Panic**

- Palpitation
- Sweats
- Shakes/tremble
- Shortness of breath
- Chest pain
- Nausea
- Dizzy
- Fear of dying
- Agoraphobia

**PTSD**

- Trauma
- Nightmares
- Flashbacks
- Hypervigilant
- Avoidant
- Insomnia
- Startle response

**OCD**

- Obsession
- Obsessions
- Compulsions

**ODD**

- Argues
- Defiant
- Blames others
- Angry
- Vindictive
- Loses temper

**Mania**

- Grandiose
- Racing thoughts
- Minimal sleep
- Excessiveness
- Agitation

**ADHD/ADD**

- Short attention span
- Distractible
- Poor concentration
- Forgetful
- Organizational problems
- Fidgety/restless
- Impatient
- Underachievement
- Difficulty completing tasks
- Procrastination
- Misplaces things
- Easily frustrated
- Impulsive/reactive
- Hyperactive

**Conduct disorder**

- Cruelty
- Theft
- Aggression
- Fights
- Fire setting
- Destructive
- Run away
- Truant

**Impairments to progress:**

Complex circumstances \_\_\_\_\_ Chronic circumstances \_\_\_\_\_ Low motivation \_\_\_\_\_  
 Unproductive past therapy \_\_\_\_\_ Chronic health probs \_\_\_\_\_ Interpersonal \_\_\_\_\_  
 Occupational/Educational \_\_\_\_\_ Chronic emotional probs \_\_\_\_\_ Psychological \_\_\_\_\_ Compliance \_\_\_\_\_

**Client strengths:**

Spiritual faith \_\_\_\_\_ Motivation \_\_\_\_\_ Social support \_\_\_\_\_ Hopefulness \_\_\_\_\_ Honesty \_\_\_\_\_ Confidence \_\_\_\_\_  
 Willingness to take responsibility \_\_\_\_\_ Accurate self assessment \_\_\_\_\_  
 Others \_\_\_\_\_