

FAMILY PSYCHOLOGY ASSOCIATES, P.C.

Medical and Social History Form

This is not a test - just a way for your counselor to get to know you.
We understand that you may feel uncomfortable about divulging personal information.
If you are uncomfortable about any question on this form, talk to your counselor about it.

Name: _____ Today's Date: _____

Address: _____

Date of Birth: _____ Age: _____ Race: _____

(optional)

FAMILY INFORMATION:

Current Living Situation:

Marital status: ☐Never Married ☐Cohabiting ☐Married ☐Separated ☐Divorced ☐Widowed

If not living alone, with whom are you now living? _____

If Married

Spouse=s Name: _____ Date of Birth _____ Date of Marriage _____

If this is not your first marriage, note the dates of previous marriage(s) and the name(s) of your previous spouse(s) _____

Describe your spouse=s (or companion=s) personality _____

Is your present relationship satisfactory? If not, specify what is unsatisfactory _____

Names and ages of your children: _____

Do you have special concerns about any of your children? Is so, explain _____

Family of Origin:

Names, ages and marital status of your parents _____

Names and ages of brothers _____

Names and ages of sisters _____

Describe your family life as you were growing up _____

PERSONAL INFORMATION:

Educational level achieved: Self _____ Spouse _____

If you are currently a student list name of school and full or part-time status _____

What is your current job? _____

How long have you held your current job? _____

What other types of work have you done? _____

If employment problems are part of your reason for seeking counseling, specify _____

Religion: Self _____ Spouse _____

Please complete form on reverse side.

HEALTH INFORMATION:

Physician: _____

Have you sought counseling previously? If so, who did you see, why and when? _____

Was that counseling satisfactory? Why or why not? _____

What is your current reason for seeking counseling? _____

Do you have any major medical problems? If so, please describe _____

Have you ever had a major head injury? _____

Do you ever lose control of your anger? If so, explain _____

Have you, or a family member, ever been hospitalized for emotional problems? If so, please explain when, where and why _____

Are you currently or have you ever had thoughts of harming yourself or others? If so, please explain _____

Are you currently taking any medications? If so, please state which ones, dosage and how long you have been on them _____

Do you have any allergies? If so, are you currently taking medications for allergies? _____

Have you ever become dependent on any doctor prescribed medications? If so, explain _____

ALCOHOL AND DRUG USE:

Have you ever felt you ought to cut down on your drinking? _____

Have people annoyed you by criticizing your drinking? _____

Have you ever felt bad or guilty about your drinking? _____

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye opener)? _____

How much alcohol do you consume in a week? _____

Have you ever used any illegal drugs? If so, which ones and how often? _____

Has drinking or drug use caused you problems with the law or at work? If so, explain _____

Have you ever sought treatment for substance abuse? If so, describe when and where and what effect it had on your use _____

Has anyone in your family had problems with substance use or treatment for substance use? If so, explain _____

Thank you for filling out this form. Your answers will be kept confidential.