

Client Psychosocial History

Recall as much as possible from your childhood to the present. If you have any questions or you feel unsure of a particular statement, leave the questions blank.

1. **Parents:**

Biological, step-parents, or individual who raised you: _____

Identify the individual who used drugs or alcohol: _____

Identify the individual who had legal problems: _____

Identify the individual whom you feel abused you: _____

Circle all that apply: Physically Verbally Emotionally Sexually

2. **Marital Status:** Married Divorce Widowed Single Common-law Spouse

How would you describe your relationship? _____

3. **Siblings:**

Biological sisters, brothers, step-brothers, step-sisters: _____

How Many? _____

Describe your relationship with them: _____

Identify the individual who uses alcohol or drugs: _____

Identify the individual whom you feel abused you: _____

Circle all that apply: Physically Verbally Emotionally Sexually

4. **Education:**

Type of school: Boarding School Private School Public School

Years of education, from 1st grade through college: _____

High School Graduate or GED certificate: _____

Reason for dropping out (if applicable): _____

5. **Legal Problems:**

Type: _____ Date: _____

Incarcerated for offense? YES NO To: _____ From: _____

Where? _____

Type: _____ Date: _____

Incarcerated for offense? YES NO To: _____ From: _____

Where? _____

Are you on Probation? YES NO

Name of Probation Officer: _____

Phone # _____

6. **Prior Treatment or Rehabilitation:**

Name of Facility: _____

Treatment was for: Alcohol Drugs To: _____ Date: _____

Name of Facility: _____

Treatment was for: Alcohol Drugs To: _____ Date: _____

7. **Drugs or Alcohol Usage:**

At what age did you start to experiment with drugs or alcohol? _____

List the type of alcohol or drugs used: _____

Amount of consumption: _____ Daily Weekly Monthly

8. **Psychological Assessment:**

Name of facility: _____

Date of assessment: _____ Reason for assessment: _____

Conclusion of assessment (list any or all disorders): _____

9. **Medical Problems:**

Date of last Physical Exam: _____ Date of last TB test: _____

Type of medical problems: _____

Limitations due to medical disability: _____

Are you taking any medications? YES NO

If so what kind? _____

10. What do you consider to be your strengths? _____

11. What do you consider to be your weak areas in your life? _____

12. What are your expectations from this treatment program? _____

NAME: _____ **DATE:** _____