MICHELLE LISKA
THERAPY

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Personal Psychosocial History

Client Legal Name: _____Name you'd like me to call you: _____

Age of Client: _____Today's Date: _____

Person (if any) completing form for client: _____

Relationship to client:_____

THANK YOU for taking your time to complete this form. The form is long, but the more information you provide will help your therapist better understand you. You may also use the back of this form if necessary.

Please tell me what recently occurred that caused you to seek help now?

_____

_____

	First Name	Age	Living with you? (Yes/No)	If deceased, year & cause
Father				
Mother				
Stepfather				
Stepmother				
Current Spouse				
1st marriage--Spouse				
2nd marriage--spouse				

Siblings--biological (oldest to youngest)				
Siblings--half (please state mom or dad's side of family)				
Siblings--step (please state mom or dad's side of family)				
Your Children				
Your Stepchildren				

Marital Status

Married _____ (if so, how many months/years? _____) Living together: _____ Unmarried: _____ Separated: _____ Divorced: _____ Widowed: _____

Number of times you have been married: _____

How long married each marriage: _____

Number of years between marriages: _____

Who raised you? _____
(If adopted, please describe the adoption on the back of this sheet)

Parents' current marital status: _____

If parents are divorced, how old were you at the time of the divorce? _____

If parents divorced and remarried, how old were you at the time of the remarriage(s)?

_____

Which of your family members would you say is the closest to you now?

_____

Cultural Background

How do you self-identify your race and ethnicity? _____

How do you self-identify your sexual orientation (asexual, gay, lesbian, bisexual, heterosexual, queer, pansexual, polyamorous, fluid, other)?

How do you self-identify your gender (female, male, cis gendered, fluid, trans, other—**please indicate what pronouns you'd like me to use)?**

_____

Religious/spirituality preference: _____

Are your currently active in your religion? (Circle one): Yes / Somewhat / No

Educational Background

What grade did you complete in high school? _____ Did you receive a diploma? _____

What certificates or licenses, if any, have you received? _____

Have you attended college? _____ How many hours did you complete? _____What was your

major? _____Where did you attend college? _____

Did you receive a college degree and if yes, what was the degree? _____

What other advanced degrees, if any, have you received? _____

Medical Information

Have you ever been hospitalized? (If so, for what reason?)

_____

Do you have any major health problems (please list)?

_____

_____

Primary Physician's Name: _____ Phone: _____

Physicians Address: _____

Date of your last physical: _____ Results: _____

Please list any medications that you are currently on and the illnesses they are treating:

_____

_____

Do you skip meals often? _____ Do you eat a well-balanced diet? _____

Have you struggled with any disordered eating/had an eating disorder? _____

Do you exercise regularly? _____ How often? _____ What type of exercise? _____

For women

Number of pregnancies: __ Live births: _____ Miscarriages: ___ Stillbirths: _____ Abortions: _____

Did you ever experience post partum depression? If so, for how long?
_____

Do you have a normal menstrual cycle? _____ Are you currently pregnant? _____

Do you experience premenstrual syndrome (PMS)? _____

Are you currently experiencing premenopausal symptoms? _____ Are you currently in menopause? _____

What are your current premenopausal symptoms?
_____

R Check here if you or your family members (family of origin and current family members) DO NOT have a history of a substance use disorder. If you check this circle, please proceed to page 6, ("Employment"section) of this form and continue.

Chemical Use History

Tobacco
Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Current use daily/weekly: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Alcohol
Use (Y or N): ____ Age of 1st use: _____

Current use daily/weekly: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Marijuana
Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Current use daily/weekly: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Prescription or over the counter (OTC) medication use/abuse (using prescription medication that was or was not your prescription to get high; using OTC medication to get high)
Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Current use daily/weekly: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Caffeine (coffee, caffeinated sodas, energy drinks, tea)
Use (Y or N): ____ Age of 1st use: _____

Current use daily/weekly: _____

If you used to use this substance, when and why did you quit using? _____

Cocaine (all forms)
Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Current use daily/weekly: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Heroin/opioids

Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Current use daily/weekly: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Methamphetamine

Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Current use daily/weekly: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Hallucinogens

Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Current use daily/weekly: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Inhalants (huffing)

Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Current use daily/weekly: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Family History of Substance Use Disorder(s):

Have any family members of yours had a problem with a substance use disorder? _____

Who? _____

What substance(s):_____

Chemical use associated problems (answer Y or N):

Blackouts _____

Physical problems _____

Financial stress _____

Inattentiveness to responsibilities (job, family, appointments, etc) _____

Family/friend/employer concerns _____

Other addiction behaviors (answer Y or N):

Gambling _____

Out-of-control sexual behavior _____

Spending _____

Internet _____

Shoplifting/stealing _____

Working too much _____

Past and Current Substance Use Disorder Treatment

History of substance use disorder treatment (answer Y or N): _____

Outpatient: Current Provider: _____ Past provider(s): _____

Intensive Outpatient Program (IOP): Current Provider: _____ Past provider(s): _____

Inpatient Substance Abuse: Current Provider: _____ Past provider(s): _____

Current/past participation in support (12-step or other) groups (answer Y or N): _____

Sponsor (answer Y or N): _____

Current/past history of use of the following for substance use disorder treatment(s):

Suboxone/Methadone: When/length of use: _____

Medical Marijuana: When/length of use: _____

Employment

What do you do for work? _____

Current employer: _____ Job Title: _____Years at this job: _____

Have you ever been fired from a job? _____ Why? _____

Do you have any problems with your current job? _____

Financial

Do you have financial problems? _____

What types of financial aid, if any, do you receive? _____

What types of financial aid, if any, do other members of your household receive? _____
_____

Legal History

Have you ever been arrested? ____ Why were you arrested? _____

Arrest date(s): _____ Were you convicted? _____

Have you been on parole/probation? _____ Dates of parole/probation _____
_____

Symptom(s) Checklist (Check any symptoms that apply whether problem heading is correct or not)

Depression

Chronic sadness		Low frustration tolerance		Hopelessness	
Crying episodes		Irritability		Sleep problems	
Difficulty concentrating		Memory problems		Weight loss	
Thoughts of suicide		Weight gain		Withdrawing from others	
Loss of appetite		Difficulty functioning at work		Overeating	
Difficulty socially		Nausea/Vomiting		Low energy/fatigue	
Difficulty making decisions		Reduced interest in hobbies		Reccurring thoughts of death	
Feelings of worthlessness/guilt					

Anxiety

Agitation		Restlessness		Excessive worry	
Fearfulness		Trembling/Shaking		Fear of loss of control	
Fear of dying		Panic attacks		Fear of leaving home	
Avoidance of public places		Avoidance of social situations		Chest pain	
Shortness of breath					

Stress/Trauma

Feelings of detachment		Intrusive bad memories		Upsetting flashbacks	
Nightmares		Easily startled/upset			

Eating Problems

Excessive Eating		Underweight		Use of laxatives	
Eating interfering with health		Obesity		Self-induced vomiting	
Obsessing about diet					

Thinking Problems

Hearing voices others do not		Excessive self-consciousness		Fear others are plotting against you	
Seeing things others do not					

Attention and Behavior

Difficulty completing tasks		Difficulty focusing		Tendency to be impulsive	
Unorganized		Problems with co-workers		Problems with authorities	
Taking on too many tasks		Frequent forgetfulness		Difficulty with patience	
Difficulty keeping jobs		Problems maturing			

Other Problem Areas

Racing thoughts		Excessive spending		High risk sexual behavior	
Worried about sexual behavior		Serious parent-child conflicts		Insomnia/lack of sleep	
Excessive gambling		Abuse towards others		Serious marital conflicts	
Frequent family conflicts					

Which of the above concerns are most **important** to you?

Most important: _____

Second most: _____

Third most: _____

Mental Health History

Have you been in counseling/behavioral or mental health therapy before? _____

When and where? _____

Do you have a pre-existing mental health diagnosis? If so, what is the diagnosis?

_____

Do any of your family members have a mental health diagnosis? If so, what family member and what is the diagnosis/diagnoses?

Have you ever had any thoughts of harming yourself or wishing you were dead? (If so, have you experienced these thoughts recently? Explain)

Have you ever attempted to commit suicide or seriously harm yourself? (If so, please explain when, how, and why)

Have you ever been psychiatrically hospitalized? _____

Has anyone in your family ever attempted to commit suicide? _____ Who? _____

Please explain _____

Is your partner ever afraid of you? _____ Are your children? _____

Have you ever abused any of your loved ones? _____ Who? _____

Have you ever been the victim of physical, sexual, or verbal abuse (as a child or as an adult)?

Military Experience

Have you served in the military? Y or N If yes, what branch? _____

What was your rank at discharge? _____ Honorably discharged? _____

Loss Issues

Please summarize any significant losses you have experienced in your life:

Summary

Please feel free to explain any thoughts or feelings about previously checked items:

Please write down any questions for your therapist:

The above information is given freely and is true to the best of my knowledge.

I understand that no information about me or my treatment will be divulged to any person outside of counseling without my written consent, with the following exceptions: 1) in the event that there is clear and imminent threat of harm toward me or against another person; 2) if there is intent to commit criminal activity or awareness or suspicion of such toward a minor or an elder; and 3) if a court order requiring my testimony, under legal consultation, in response to my raising the issue of mental health in a lawsuit or when minors have limited rights of confidentiality.

Date: _____ Signature: _____