The Wellness Institute of Michigan
Adult Psychosocial History

PATIENT NAME:_____DATE:_____

DATE OF BIRTH:_____ AGE:_____ SEX: ☐MALE ☐FEMALE

WHO REFERRED YOU?_____

BRIEFLY DESCRIBE THE REASON FOR YOUR VISIT TO US: _____
_____
_____
_____

ARE YOU **RIGHT HANDED** OR **LEFT HANDED**? (PLEASE CIRCLE ONE)

EARLY HISTORY

WERE YOU BORN: ☐**ON TIME** ☐**PREMATURELY** ☐**LATE**
BIRTH WEIGHT: _____
WERE THERE ANY PROBLEMS ASSOCIATED WITH:
YOUR MOTHER'S PREGNANCY (DESCRIBE): _____
YOUR BIRTH (OXYGEN DEPRIVATION, UNUSUAL BIRTH POSTION, ETC): _____
THE PERIOD IMMEIDATELY AFTER BIRTH (SPECIAL EQUIPMENT USED, CONVULSIONS, ILLNESS, ETC.)
_____

RATE YOUR DEVELOPMENTAL PROGRESS TO THE BEST OF YOUR KNOWLEDGE:

	EARLY	AVERAGE	LATE
WALKING	☐	☐ (9-18 mo)	☐
LANGUAGE	☐	☐ (12-24 mo)	☐
TOILET TRAINING	☐	☐ (13-36 mo)	☐

AS A CHILD, DID YOU HAVE ANY OF THESE CONDITIONS? (CHECK ALL THAT APPLY)

☐ FREQUENT EAR INFECTIONS	☐ HEAD INJURY	☐ BEHAVIORAL PROBLEMS
☐ CLUMSINESS	☐ HEARING PROBLEMS	☐ SPEECH PROBLEMS
☐ DEVELOPMENTAL DELAY	☐ HYPERACTIVITY	☐ VISION PROBLEMS
☐ ATTENTION PROBLEMS	☐ LEARNING DISABILITY	☐ PSYCHOLOGICAL PROBLEMS

FAMILY HISTORY

BIOLOGICAL FATHER

(CIRCLE ONE) LIVING DECEASED	AGE (IF LIVING): AGE IF DECEASED:	CURRENT HEALTH (IF LIVING)/CAUSE OF DEATH (IF DECEASED):
MARITAL STATUS:		OCCUPATION:
LOCATION:	DESCRIBE RELATIONSHIP:	

BIOLOGICAL MOTHER

(CIRCLE ONE) LIVING DECEASED	AGE (IF LIVING): AGE IF DECEASED:	CURRENT HEALTH (IF LIVING)/CAUSE OF DEATH (IF DECEASED):
MARITAL STATUS:		OCCUPATION:
LOCATION:	DESCRIBE RELATIONSHIP:	

STEP MOTHER (IF APPLICABLE) NAME: _____

(CIRCLE ONE) LIVING DECEASED	AGE (IF LIVING): AGE IF DECEASED:	CURRENT HEALTH (IF LIVING)/CAUSE OF DEATH (IF DECEASED):
MARITAL STATUS:		OCCUPATION:
LOCATION:	DESCRIBE RELATIONSHIP:	

STEP FATHER (IF APPLICABLE) NAME: _____

(CIRCLE ONE) LIVING DECEASED	AGE (IF LIVING): AGE IF DECEASED:	CURRENT HEALTH (IF LIVING)/CAUSE OF DEATH (IF DECEASED):
MARITAL STATUS:		OCCUPATION:
LOCATION:	DESCRIBE RELATIONSHIP:	

IF YOUR BIOLOGICAL PARENTS WERE DIVORCED, HOW MANY YEARS WERE THEY MARRIED?_____
HOW OLD WERE YOU WHEN THEY DIVORCED? _____

SIBLINGS BIOLOGICAL AND/OR STEP SIBLINGS

NAME OF SIBLING	BIO-LOGICAL /STEP	AGE	SEX	SCHOOL/ OCCUPATION	GRADE	LIVES AT HOME	USES DRUGS/ ALCOHOL	TREATED FOR DRUGS/ ALCOHOL?
	B S		M F			Y N	Y N	Y N
	B S		M F			Y N	Y N	Y N
	B S		M F			Y N	Y N	Y N
	B S		M F			Y N	Y N	Y N
	B S		M F			Y N	Y N	Y N

CHILDREN

DO YOU HAVE ANY CHILDREN? ☐**YES** ☐ **NO**

CHILD'S NAME (PLEASE INCLUDE STEP CHILDREN)	CHILD'S AGE	CHILD'S LOCATION	DESRIBE CURRENT RELATIONSHIP

CURRENT LIVING ARRANGEMENTS

WHO LIVES IN YOUR HOME NOW? _____
SATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐COHABITATING
HOW MANY TIMES HAVE YOU BEEN MARRIED? _____
NAME OF CURRENT SPOUSE/PARTNER: _____ AGE: _____
DURATION OF RELATIONSHIP? _____
CURRENT OCCUPATION OF PARTNER/SPOUSE: _____
CURRENT MEDICAL CONDITION OF PARTNER/SPOUSE: _____
DESCRIBE CURRENT RELATIONSHIP: _____
_____
LIST PREVIOUS RELATIONSHIPS/MARRIAGES, INCLUDING NUMBER OF YEARS, AND REASONS RELATIONSHIPS ENDED: _____
_____

MENTAL HEALTH HISTORY

HAVE YOU BEEN INVOLVED IN PSYCHOLOGICAL/PSYCHIATRIC TREATMENT? (CIRCLE ONE) YES NO
IF YES, WHEN AND WITH WHOM? _____
WHO SUGGESTED TREATMENT? _____
FOR WHAT WERE YOU TREATED? _____
HAVE YOU EVER HAD A PSYCHOLOGICAL EVALUATION BEFORE? YES NO IF YES, WHEN AND WITH WHOM? _____
HAVE YOU EVER BEEN IN A PSYCHIATRIC HOSPITAL? YES NO IF YES, PLEASE DESCRIBE. _____
_____

SYMPTOMS/STATUS

DESCRIBE YOUR SYMPTOMS: _____

_____

MY SYMPTOMS HAVE DEVELOPED: (CIRCLE ONE) **SLOWLY QUICKLY**

OVER THE PAST 6 MONTHS MY SYMPTOMS HAVE: (CIRCLE ONE) **STAYED THE SAME WORSENED**

DESCRIBE YOUR RECENT APPETITE: _____

HAVE YOU EXPERIENCED RECENT WEIGHT LOSS/GAIN? _____

DESCRIBE YOUR RECENT SLEEP PATTERNS: _____

DESCRIBE ANY MEDICAL AND/OR PSYCHOLOGICAL CONDITIONS THAT RUN IN YOUR FAMILY. PLEASE INCLUDE ANY SUICIDES OR HOMICIDES.

FAMILY MEMBER	MEDICAL/PSYCHOLOGICAL CONDITIONS

MEDICAL HISTORY

MEDICAL DIAGNOSIS, IF ANY: _____

MEDICAL ILLNESSES AS A CHILD:_____

_____

_____

_____

MEDICAL ILLNESSES AS AN ADULT:

_____

_____

SURGERIES: ☐**YES** ☐**NO**

WHAT?	WHEN?	WHERE?

NEUROLOGICAL (HEAD INJURIES, SEIZURE, STROKE, CONCUSSION, ETC.) ☐**YES** ☐**NO**

WHAT?	WHEN?	WHERE?

OTHER HOSPITALIZATIONS: ☐**YES** ☐**NO**

WHAT?	WHEN?	WHERE?

SUBSTANCE USE/HISTORY

HAS ANY MEMBER OF YOUR FAMILY EXPERIENCED DRUG OR ALCOHOL ABUSE? ☐**YES** ☐**NO**
IF YES, PLEASE EXPLAIN: _____
_____
DO YOU CURRENTLY DRINK ALCOHOL? ☐**YES** ☐**NO**
IF YES, WHAT TYPE OF ALCOHOL DO YOU DRINK (CHECK ALL THAT APPLY)?
☐**BEER** ☐**WINE** ☐**LIQUOR** **OTHER:** _____
HOW OFTEN DO YOU DRINK? ☐**DAILY** ☐**WEEKLY** ☐**MONTHLY** ☐**OCCASSIONALLY**
HOW MUCH DO YOU DRINK? _____
HAS YOUR ALCOHOL USE INTERFERED WITH WORK OR RELATIONSHIPS (i.e., FIRED, FAMILY/MARITAL PROBLEMS)? ☐**YES** ☐**NO**
IF YES, EXPLAIN: _____
_____
HAVE YOU EVER BEEN TREATED FOR ALCOHOL ABUSE? ☐**YES** ☐**NO**
IF YES, EXPLAIN: _____
_____
DO YOU CURRENTLY USE OTHER DRUGS? ☐**YES** ☐**NO**
IF YES, WHAT KIND OF DRUGS DO YOU USE (CHECK ALL THAT APPLY)?
☐**MARIJUANA** ☐**COCAINE** ☐**HEROIN** ☐**METHAMPHETIMINES** ☐**OPIATES**
☐**BENZOS** ☐**OTHER (EXPLAIN):** _____
HOW OFTEN DO YOU USE? ☐**DAILY** ☐**WEEKLY** ☐**MONTHLY** ☐**OCCASSIONALLY**
HOW MUCH DO YOU USE? _____
HAS YOUR DRUG USE INTERFERED WITH WORK OR RELATIONSHIPS (i.e., FIRED, FAMILY/MARITAL PROBLEMS)? ☐**YES** ☐**NO**
IF YES, EXPLAIN: _____
_____
HAVE YOU EVER BEEN TREATED FOR DRUG ABUSE? ☐**YES** ☐**NO**
IF YES, EXPLAIN: _____
_____

EDUCATIONAL HISTORY

CURRENTLY IN SCHOOL? ☐**YES** ☐**NO**
IF YES, SCHOOL CURRENTLY ATTENDING: _____
HIGHEST GRADE EARNED: _____ FROM WHAT SCHOOL? _____
DESCRIBE YOUR USUAL PERFORMANCE AS A STUDENT: ☐**A/B** ☐**B/C** ☐**C/D** ☐**D/F**
PLEASE PROVIDE ANY ADDITOINAL HELPFUL COMMENTS ABOUT YOUR ACADEMIC PERFORMANCE:_____
WHAT WAS YOUR STRONGEST SUBJECT(S)? _____
WHAT WAS YOUR WEAKEST SUBJECT(S)? _____

PLEASE RATE YOUR ABILITIES IN THE FOLLOWING:
SPELLING (CIRCLE ONE): **EXCELLENT** **GOOD** **FAIR** **POOR**
READING (CIRCLE ONE): **EXCELLENT** **GOOD** **FAIR** **POOR**
ARITHMETIC (CIRCLE ONE): **EXCELLENT** **GOOD** **FAIR** **POOR**
DID YOU EVER REPEAT A GRADE? YES NO IF YES, WHAT GRADE(S)? _____
REASON FOR REPEATING GRADE: _____

WERE YOU EVER IN ANY SPECIAL CLASS(ES) OR RECEIVE SPECIAL SERVICES FOR LEARNING DIFFICUILTIES? EXPLAIN: _____
_____

EMPLOYMENT HISTORY

CURRENTLY EMPLOYED? ☐YES ☐NO
EMPLOYER _____
JOB TITLE:_____
DURATION? _____
HAVE YOU EVER BEEN EXPOSED TO TOXIC OR HAZARDOUS SUBSTANCES ON THE JOB? IF YES, EXPLAIN:_____
_____
WHAT IS YOUR OCCUPATIONAL SATISFACTION? _____

HOW MUCH STRESS DO YOU HAVE AT YOUR JOB? ☐**NONE** ☐**SOME** ☐**AVERAGE** ☐**VERY HIGH**

LEGAL HISTORY

HAVE YOU EVER BEEN ARRESTED/CONVICTED OF A CRIME? ☐**YES** ☐**NO**
IF YES, EXPLAIN (PLEASE INCLUDE WHEN AND WHAT IT WAS FOR): _____
_____
_____
ARE YOU CURRENTLY ON PROBATION/PAROLE? ☐**YES** ☐**NO** IF YES, ARE YOU COURT ORDERED TO BE HERE? ☐**YES** ☐**NO**
IF YES, EXPLAIN: _____

MILITARY

MILITARY SERVICE? ☐**YES** ☐**NO**
IF YES, WHAT BRANCH? _____
WHEN? _____ WHERE? _____
DISCHARGE DATE: _____ DISCHARGE STATUS: _____
ARE YOU A COMBAT VET? ☐**YES** ☐**NO** IF YES, EXPLAIN: _____

HISTORY OF ABUSE

ARE YOU CURRENTLY BEING ABUSED IN ANY WAY (PHYSICAL/SEXUAL/EMOTIONAL)? ☐**YES** ☐**NO**
IF YES, EXPLAIN: _____
_____
DO YOU HAVE ANY CONCERNS FOR YOUR SAFETY TODAY? ☐**YES** ☐**NO**
IF YES, EXPLAIN: _____
_____

IS THERE ANY PHSYICAL VIOLENCE, HITTING, CONTROLLING BEHAVIORS BY ANYONE IN YOUR HOME OR BY YOU?
☐**YES** ☐**NO** IF YES, DESCRIBE: _____
_____

PERSONAL

HOW DO YOU SPEND YOUR FREE TIME? _____
WHAT OTHER INTERESTS WOULD YOU LIKE TO PURSUE? _____
WHO DO YOU COUNT ON FOR SUPPORT IN TIME OF TROUBLE? _____
_____

IS THERE ANYTHING ELSE THAT YOU WOULD LIKE US TO KNOW THAT MAY HELP US UNDERSTAND HOW WE CAN HELP YOU? _____
_____
_____
_____
_____

_____ _____

PATIENT SIGNATURE **DATE**

MEDICATION LIST

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. PLEASE CONTINUE ON BACK IF YOU NEED MORE ROOM

NAME OF MEDICATION	DOSAGE	AGE	LENGTH TAKEN	REASONS