Adult Outpatient Self-Report of History and Social Factors

Patient name: _____ Patient #: _____

Date: _____

Marital and Family History/Living Arrangements/Custody Status

Marital Status: ☐ Single, Never Married ☐ Single, Divorced ☐ Single, Cohabitating
☐ Married ☐ Separated ☐ Widowed

Times Married: _____ Times Divorced: _____

Living Status (check those that apply):
☐ Living Alone ☐ Living with Roomate ☐ Living with Spouse/Significant Other
☐ Living with children ☐ Living apart from children ☐ Living with parents
☐ Living with caretakers/guardians
Specify (if latter, include custody status):

Biological children: No Yes
If yes, list names and ages:

Step/Adoptive Children: No Yes
If yes, list names and ages:

Family History

Biological Parents:

Mother's Name - Age: Occupation:
If deceased, please list cause of death:

Father's Name - Age: Occupation:
If deceased, please list cause of death:

Step Parents: ☐ No ☐ Yes
If yes, specify name, age and occupation:

Guardians: ☐ No ☐ Yes
If yes, specify name, age and occupation:

Adoptive Parents: ☐ No ☐ Yes
If yes, specify name, age and occupation:

Birth Order: ☐ Only child ☐ First ☐ Second ☐ Third or greater

Step/Adoptive Siblings: ☐ None ☐ Yes
If yes, specify name and age:

Continuation sheet— Adult Outpatient Self-Report of History and Social Factors

Social History

Abuse/Victimization History

Check below the type(s) of abuse/victimization, if any, that you have experienced:

☐ Physical Abuse/Assault ☐ Emotional Abuse ☐ Sexual Abuse/Molestation
☐ Rape ☐ Emotional Neglect ☐ Physical Neglect

If yes to any, describe nature and extent:

Check if above included any of the following:

☐ Domestic abuse ☐ Elder abuse ☐ Child abuse

Sexual History:

☐ Not Sexually Active Past ☐ Sexually Active Past
☐ Not Sexually Active Present ☐ Sexually Active Present

Avowed Orientation:

☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Asexual

Have you been exposed to or been at risk for exposure to any sexually transmitted diseases?

☐ No ☐ Yes If yes, describe:

Educational level attained (Grade, Years of College, Years Graduate Training plus area of emphasis):

Educational/Learning difficulties:

☐ No ☐ Yes
If yes: ☐ Past ☐ Present

☐ No ☐ Yes
Specify (nature of difficulties and previous testing):

Current Employment

☐ unemployed ☐ semiskilled worker ☐ B.A. level professional
☐ student ☐ service worker ☐ graduate level professional
☐ retired ☐ skilled worker ☐ clergy
☐ homemaker ☐ sales/clerical ☐ sports/entertainment
☐ unskilled worker ☐ owner/manager

Describe the nature of your work and the current quality of your work and work relationships:

Past Employment (check those that apply):

☐ unemployed ☐ semiskilled worker ☐ B.A. level professional
☐ student ☐ service worker ☐ graduate level professional
☐ retired ☐ skilled worker ☐ clergy
☐ homemaker ☐ sales/clerical ☐ sports/entertainment
☐ unskilled worker ☐ owner/manager

Describe briefly your work history (including consistency of employment, nature of terminations, frequency of changes, meaningfulness of jobs to you):

Hobbies and Recreation Interests (Please list, and also describe reasons why you may no longer be enjoying these interests now):

Legal Involvement

Have you ever been involved in legal proceedings?: ☐ No ☐ Yes
Have you ever been prosecuted or convicted?: ☐ No ☐ Yes
Describe details, if applicable:

Religious and Cultural Factors

Religious/Spiritual Affiliation (describe):

Are you currently active in the practice of your religion? ☐ No ☐ Yes
Are you experiencing a religious or spiritual crisis at present? ☐ No ☐ Yes
If you are, describe the nature of religious or spiritual difficulties:

Do you have any cultural or personal preferences requiring the attention or awareness of our staff?: ☐ No ☐ Yes
Check those that apply: ☐ Appearance ☐ Custom ☐ Diet ☐ Dress ☐ Religious ☐ Ritual
If yes for any, please describe:

Is English your second language? ☐ No ☐ Yes
Specify primary language (if other than English):

Social and Financial Circumstances

Social Circumstances – Are you or have you been having difficulty in any of the following areas in the past three months?

Housing: ☐ No ☐ Yes

Financial status: Annual Household income: ☐ No ☐ Yes

Access to social contacts and amenities (stores, public facilities): ☐ No ☐ Yes

Access to health and social services: ☐ No ☐ Yes

Vulnerability to victimization or discrimination: ☐ No ☐ Yes

Describe, if yes to any:

Psychiatric History

Prior Mental Illnesses – Have you experienced any emotional problems prior to the present problem?
☐ No ☐ Yes
If yes, please describe:

Continuation sheet— Adult Outpatient Self-Report of History and Social Factors

Medications

Current Medications (including over the counter (OTC) meds, in the last week)

Name	Date of Initial Prescription	Dosage and Frequency

Previous Mental Health Treatment and Care

Current treatment: (If none, move on to Past Treatment) ☐ None

	Not receiving	Receiving
Outpatient: including individual, family or group therapy		
Inpatient		
Residential		
Partial Hospital/Day Treatment		
Intensive In-Home/ Other:		

Length of current treatment: ☐ Past 6 months ☐ Past year ☐ Past 2 years
☐ Past 2-5 years ☐ Past 6-10 years ☐ More than 10 years

Brief description of current mental health treatment(s):

Please identify your current mental health care provider and describe how your current mental health treatment (medical and/or psychological) has been helpful or not:

Past Treatment:

Previous treatments received:	Not received	1 time	2-3 times	4+ times
Outpatient: including individual, family or group therapy				
Inpatient				
Residential				
Partial Hospital/Day Treatment				
Intensive In-Home Other				

Length of treatment history: ☐ Past 6 months ☐ Past year ☐ Past 2 years
☐ Past 2-5 years ☐ Past 6-10 years ☐ More than 10 years

Past Medications (including over the counter (OTC) meds)

Name	Dosage	Frequency

List any additional medications here:

Brief description of previous mental health treatment(s):

Please identify your previous mental health care provider(s) and describe how your previous mental health treatment (medical and/or psychological) has been helpful or not:

Medical History

Prior Major Physical Illnesses: ☐ None ☐ Yes
Describe:

Operations/Surgeries: ☐ None ☐ Yes
Describe:

Prior Major Injuries: ☐ None ☐ Yes
Describe:

Allergies to Medications: ☐ None ☐ Yes
Describe, including types of reactions:

Other Allergies: ☐ None ☐ Yes
Describe, including types of reactions:

Major Medical Treatments: ☐ None ☐ Yes
Describe:

Immunization Status – Age-appropriate: ☐ None ☐ Yes ☐ Uncertain
Describe:

Substance Use History

Alcohol/Drug/Substance Use (complete for each that you have used)

Substance	Type of Substance	Age Started	Last Use (Date and Time)	Current Use (Amount and Frequency)	Use at Worst (Amount and Frequency)
tobacco					
alcohol					
over-the-counter medication					
marijuana					
cocaine					
narcotics					
sedatives					
barbiturates					
amphetamines (or similar)					
other prescription medications					
hallucinogens					
inhalants					

Do you have a history of substance abuse? ☐ No ☐ Yes (If yes, continue with this section)

Age of onset of abuse:

Do you have a history of dependence on a substance? ☐ No ☐ Yes

Age of onset of dependence:

Time when alcohol abuse most severe:

☐ Past 2 weeks ☐ Past 3 months ☐ Past year ☐ Past 5 yrs ☐ More than 5 yrs ago ☐ Not applicable

Time when drugs/other substance abuse most severe:

☐ Past 2 weeks ☐ Past 3 months ☐ Past year ☐ Past 5 yrs ☐ More than 5 yrs ago ☐ Not applicable

Substances of abuse/dependence: (Specify)

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Substance Abuse Treatments:

Do you have a history of past or present substance abuse treatment? ☐ No ☐ Yes

Please describe how your current or previous substance abuse treatment (medical and/or psychological) has been helpful or not:

Family Psychiatric and Medical History:

Family History of Mental Illness: ☐ No ☐ Yes

Family History of Substance Abuse/Dependency: ☐ No ☐ Yes

Family History of Significant Physical Illness: ☐ No ☐ Yes

Do you believe that this family history is relevant to your current problems?: ☐ No ☐ Yes

BRIEF MOOD SCREENING QUESTIONNAIRE

	During the past week:	*Rarely* or none of the time (less than 1 day)	*Some* or a *little* of the time (1-2 days)	*Occasionally* or a moderate amount of time (3-4 days)	*Most* or all of the time (5-7 days)
1.	I was bothered by things that usually don't bother me.				
2.	I did not feel like eating; my appetite was poor.				
3.	I felt that I could not shake off the blues even with help from my family or friends.				
4.	I felt I was just as good as other people.				
5.	I had trouble keeping my mind on what I was doing.				
6.	I felt depressed.				
7.	I felt that everything I did was an effort.				
8.	I felt hopeful about the future.				
9.	I thought my life had been a failure.				
10.	I felt fearful.				
11.	My sleep was restless.				
12.	I was happy.				
13.	I talked less than usual.				
14.	I felt lonely.				
15.	People were unfriendly.				
16.	I enjoyed life.				
17.	I had crying spells.				
18.	I felt sad.				
19.	I felt that people disliked me.				
20.	I could not get going.				