Cedar Rapids Counseling
&Psychotherapy Group, LLP

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Cedar Rapids, IA 52402-3221

MEDICAL and SOCIAL HISTORY FORM

This form is a way for me to get to know you better and helps with completing your assessment. If there are questions that make you uncomfortable, please talk with me about it.

Name _____ **Today's Date** _____

Symptoms: Please check each concern experienced recently

__Anxiety	__Depression	__Sleep problems	__Thoughts of suicide
__Panic	__Unusual thoughts	__Anger outbursts	__Changes in weight
__Crying spells	__Memory problems	__Sexual problems	__Relationship issues
__Treated unfairly	__Frequent pain	__Low energy	__Concentration
__Restlessness	__Nausea	__Legal difficulties	__Eating Disorder
__Drug use	__Drinking problem	__Boredom	__Hopelessness
__Stress	__Shyness	__Work problems	__Confusion
__Guilt feelings	__Suspicion	__Thoughts of hurting others	__Loneliness
__Compulsions	__Worry	__Difficulty with decisions	__Money problems
__Specific fears	__Mourning	__Physical illness	__Poor motivation
__Feeling abandoned	__Meaninglessness	__Perfectionism	__Unusually sensitive
__Irritability	__Social withdrawal	__Feeling misunderstood	__Mood swings
__Religious concerns	__Disappointment	__Hearing strange voices	__Impulsive
__Feeling inferior	__Irrational thoughts	__Troublesome thoughts	__No concerns

Any additional concerns or symptoms: _____
What stresses or life changes have you experienced recently? _____
_____

Family of Origin

Parent's first names, marital status and ages _____
First names and ages of siblings _____
_____
Describe your family life as you were growing up _____
_____

Current Living Situation

Marital Status: __Never Married __Partnership __Married __Separated __Divorced __Widowed
If not living alone, with whom are you now living? _____
If Married, name of spouse _____ Age _____ Date of Marriage _____
Dates of previous marriage(s) and name(s) of previous spouse(s) _____
_____
Describe your spouse's (partner'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?_____

Personal Information

Education Level _____ If you are currently a student, list name of school _____
Current job and length of time there _____
Current job title _____ How many hours per week are you working? _____
If employment problems are a part of your reason for seeking counseling, please specify _____
_____
How do you spent personal time (list hobbies, sports, religious/spiritual activities, etc) _____
_____
How many contacts do you have each month with friends outside of work or school? _____
_____
Who can you talk with about personal feelings or private matters? _____
_____
Personal strengths/important accomplishments _____
_____

Health Information

Previous counseling or inpatient treatment _____
_____
Was that counseling/treatment satisfactory? Why or why not _____
_____
Family members who have been treated for emotional problems _____
_____
Name of Primary Care Physician _____ Psychiatrist, if any _____
When was your last physical? _____
Please list major illnesses, injuries or surgeries _____
_____
How many hours do you sleep in an average night? _____
_____
Are you currently taking any prescription or over-the-counter medications? Please list names along with dosages
_____
_____
List any allergies _____
How many drinks (containing alcohol) do you consume in an average week? _____
Have you ever used illegal drugs or abused prescription drugs? If so, which ones and how often?
_____
_____
Has drinking or drug use ever caused you legal, work or relationship problems? If so, please explain:
_____
_____
Have you ever sought treatment for substance abuse? If so, describe when, where, and what effect it had on your use:
_____
_____
Has anyone in your family had substance abuse problems? If so, please explain: _____
_____
Do you use tobacco/smoke cigarettes? _____ Amount _____
What is your caffeine intake per day?_____

Thank you for taking the time to complete this form.