PHOENIX HEALTHCARE OF ASHEVILLE, PLLC
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SOCIAL HISTORY

This information is requested so that I may save you time and money and utilize your session time most efficiently. If you have any questions, please ask me in session. All your documentation remains Private/HIPAA compliant office.

Date: _____
Referral Source: _____

Name: _____Birth Date/Age:_____

Are you court ordered to receive therapy?

Your reason(s) for seeking therapy:

What are you hoping to achieve in therapy?

MEDICAL HEALTH HISTORY

**CURRENT PRIMARY CARE PHYSICIAN
Would you sign a release for my communicating with your physician? ____

Name and Practice Name: _____
Tel No_____ Date of last physical _____

Current Health:

_____

_____

Past major illness, surgeries, accidents (including dates)

_____

_____

Any chronic pain issues? _____

What do you use to help with the pain?_____

MENTAL HEALTH HISTORY

FAMILY

Please clarify if and who has been diagnosed with:

Schizophrenia_____

Bipolar Disorder_____

Addiction:

Alcohol/Substances_____

_____

Personal previous mental health diagnoses?

_____

In session, I do hope to touch on any episodic/ traumatic events in your past related to your mental health wellbeing, including suicidality. If you would like to write anything of this at this time, please do so.

Do you exercise? Meditate/pray? How is your sleep pattern? Eating patterns?

MEDICATIONS

_____ _____
_____ _____
_____ _____
_____ _____

MARITAL/FAMILY HISTORY

Current marital status: married □ separated □ divorced □ single □ widowed □ living together

Number of marriages and years married:_____
Separation(s)_____Divorce(s)_____Annulment(s)_____
Death(s)of Spouse(s)_____

Children:
(name,age,grade)_____
_____
Miscarriages: _____
Abortions: _____
Other persons living in the household:
_____

Spouse's occupation & employer_____
Your occupation & employer_____

***History of physical/sexual/emotional abuse from anyone* □ yes □ no If yes, please identify situation:

Do you have safety concerns for anyone in your family?

PARENTS and SIBLINGS

Parents:
Mother_____ Deceased? □ yes □ no Date_____
Father_____ Deceased? □ yes □ no Date____
Currently married/living together?_____
Remarried?
Mother_____Father_____

Siblings:
Name, age and significant information about siblings, living and deceased.
_____
_____

EDUCATION

HS_____ Graduation_____
Undergraduate_____ Graduation_____
Graduate_____ Graduation_____

MILITARY

Have you ever been or are you now in the Military?

Branch /Rank /Year /Time in_____

Outcome?_____

SUBSTANCE ABUSE HISTORY/REHAB

Prescription drugs:_____
OTC drugs:_____
Illicet drugs:_____
Caffeine/Tobacco use:_____

Amount of Alcohol consumed
weekly:_____
Frequency of any unprescribed drugging:_____
Age at first use of alcohol/other drugs:_____
Are you in AA/NA currently or in the past?_____
Alcohol/Drug use of other family
members:_____

FAMILY MENTAL HEALTH HISTORY

Please list significant medical and mental health treatment of grandparents, parents, siblings, and children:

Lawsuits? Family/yourself?

Incarcerations? Family /yourself?

Please describe any recent major stressors that have occurred in your life, (ex. Death, moves, changes in job, new baby)

ADDITIONAL COMMENTS: Please add any additional information regarding your social history, which you believe is important for me to know.