DOUGLASVILLE PSYCHOTHERAPY CENTER AT OAKHILL, P.C.

1111 Bakers Bridge Road
Douglasville, GA 30134
770-947-2311

Adult Psychosocial

Date _____
Name _____ DOB _____ SS# _____
Address _____ Age _____ Sex _____
City _____ State _____ ZIP _____
Marital Status: Single _____ Married _____ Divorced _____
Home Phone _____ Work _____ Cell _____
E-mail _____
Employer/School _____
Occupation _____ Position/Grade _____
Referred By: _____
May we contact referral source? _____
Legal Guardian (if minor) _____
Home Phone _____ Cell Phone _____ Work _____
Please Note: You will need to provide legal documentation showing guardianship, on next visit
Notify In An Emergency _____
Relationship _____ Phone _____
Alternate Phone _____
Present Complaint/Reason for Referral _____
_____
_____
Have you ever been to counseling before? _____ If so, when? _____
Name of doctor you visited _____
Reason _____ Diagnosis _____
Length of time in counseling _____ (00/00-00/00)
List all medications taken in the past:

Medication	Dosage	Purpose	Physician	Duration

List any known allergies: _____
Household Members (other than yourself)
First Name Relationship Age
_____
_____
_____

Social History
Personal Information/Treatment Plan

One of the goals of treatment is for clients to gain a better understanding of themselves and their particular situation. The purpose of this Social History is twofold. First, completing the Social History will enable you to take a look at past and current life experiences that helped to make you who you are today. Second, the Social History will enable me to understand you better thus will help me to better assist you in acquiring coping skills that will benefit both you and your family.

Primary Physician _____ Psychiatrist _____
Date of Last Physical Examination / Psychiatric Evaluation _____
Current Medications and Dosage _____
_____

Physical Problems / Diagnosis (if known)
1. _____
2. _____
3. _____

Have you had a recent significant weight Gain or Loss? _____ How much?_____
Average hours of sleep per night? _____ Restless or Restful? _____
Have you been diagnosed with: HIV ___ Hepatitis C ___ HBP ___ Diabetes ___ Seizures ___
Do you use drugs or alcohol? _____ How much?_____ How Often? _____ Alone or with others? _____Alcohol or Drugs of Choice? _____
Last used? _____Does your use concern you? _____

Check Anv Of The Following That May Apply:

____Agitated	____Angry	____Anxious	____Alcohol Problem
____Hostile	____Unassertive	____Suicidal	____Eating Disorder
____Homicidal	____Panic	____Phobias	____Hallucinations
____Depressed	____Guilty	____Headaches	____Sexual Problems
____Blackouts	____Insomnia	____Drug Problems	____Fatigue Difficulty
____Nightmares	____Suspicious	____Concentration	____Eating Disorder
____Jealousy	____Flashbacks	____Vision Problems	____Stomach Trouble
____Confused	____Memory Loss	____Loss of time	____Hearing Problems
____Grief	____Job Problems	____Rebellious	____Socially Withdrawn
____No Appetite	____Dizziness	____School Problems	____Emotionally Numb
____Inferior	____Temper Issues	____Marital Problems	____Rapid Mood Change
____Amnesia	____Frequently Ill	____Very Fearful	____Problems with Parents
____Compulsive Activities	____Relationship Problems		____Recurring Unwanted Thought
____Obsessive Thoughts	____Out-of-Body Experience		____Impulsive Behavior
____Problems w/ Children	____Persistent Worry		____Problems w/ Parents

Other Complaints _____

MARRIAGE AND FAMILY:

Are you currently married? _____ Name of Spouse_____
Number of children shared w/ this spouse? _____
How long have you been married? _____ How long did you date your spouse? _____
What attracted you to your spouse? _____
_____
How do you and your spouse settle disagreements? _____
_____
What are some common areas of disagreements in your marriage? (Check all that apply, add more if needed)

____Money	____Children	____Household Task
____In-Laws	____Hobbies	____Use of Free Time
____Sex	____Socializing	____Goals, Plans
____Friends	____Trust, Jealousy	____Decision Making

Other: _____
_____

How many times have you been married?
(Excluding current marriage)

Age @ time of marriage	Length of courtship	Length of marriage	Number of Children	Current Age / Sex	Briefly Reason for divorce

List All Individuals Living In the Home:

Name Relationship Age Sex School Present grade Living at home Uses Drugs

_____
_____
_____
_____
_____

HEALTH OF FAMILY MEMBERS

List other extended family members by their relationship to the patient and/if they have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems.

Name: _____ Relationship: _____ Type of Issue:_____

Name: _____ Relationship: _____ Type of Issue:_____

Name: _____ Relationship: _____ Type of Issue:_____

RECREATIONAL:

How do spend your free time? _____

_____

What hobbies did/do you enjoy? _____

Do you set time aside just for yourself? _____How often? _____Amount? _____

How often do you go out to have fun by yourself? _____With your friends? _____

With family? _____ With your spouse? _____

Do you call or keep in touch with friends, family or neighbors? _____

What was the most fun you have ever had? _____

When were you happiest? _____

What type of physical activity are you involved in? _____

_____

TREATMENT GOALS:

In looking at your current situation, in what areas would you like to improve? Please check all that apply and add more if needed.

____Anger Control	____Stress Management	____Fair Fighting
____Communication Skills	____Problem Solving	____Parenting
____Increasing Flexibility	____Assertiveness Skills	____Decision Making
____Socially Comfortable	____Financial Management	____Self Esteem

What personal goals do you have for therapy/counseling? _____

The Mood Disorder Questionnaire

INSTRUCTIONS: Please answer each question as best you can.	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	O	O
... you were so irritable that you shouted at people or started fights arguments?	O	O
...you felt much more self-confident that usual?	O	O
... you got much less sleep than usual and found that you didn't really miss it?	O	O
...you were more talkative or spoke much faster than usual?	O	O
...thoughts raced through your head or you couldn't slow your mind down?	O	O
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	O	O
...you had much more energy than usual?	O	O
...you were much more active or did many more things than usual?	O	O
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle the night?	O	O
...you were much more interested in sex than usual?	O	O
...you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	O	O
...spending money got you or your family into trouble?	O	O
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	O	O

3. How much of a problem did any of these cause you – like being able to work, having family, money or legal troubles, getting into arguments or fights?

_____No problem _____Minor problem _____Moderate problem _____Serious problem

4. Have any of your blood relatives (ie. Children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? _____

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?

_____

_____

Anxiety Scale

Instructions: Indicate how much you have been bothered by each symptom during the past week, including today, by checking the column that most closely corresponds to how you've been feeling.

	Not at all	Mildly	Moderately	Severely
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of the worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding or racing	0	1	2	3
Unsteady	0	1	2	3
Terrified	0	1	2	3
Nervous	0	1	2	3
Feelings of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion or discomfort	0	1	2	3
in abdomen	0	1	2	3
Faint	0	1	2	3
Face flushed	0	1	2	3
Sweating (not due to heat)	0	1	2	3

Total _____ _____ _____

Self Esteem Inventory

Answer the questions below with True (T) or False (F)

1. I usually put my best foot forward _____
2. I rarely feel embarrassed _____
3. I feel I have above average intelligence _____
4. I am quite ambitious _____
5. I can be very active _____
6. I am tenacious in matters that count _____
7. I enjoy my own company _____
8. I have strong powers of concentration _____
9. I don't feel shy or ill-at-ease with new people _____
10. When situations beyond my control go wrong, I don't blame myself _____
11. I enjoy being praised or complimented _____
12. I don't feel anxious when I have to address a group of superiors _____
13. I have fantasies of doing something great _____
14. I don't feel humiliated or hurt if someone makes a joke at my expense _____
15. I don't mind showing off my good points and getting attention for it _____
16. In general, I have lots of energy _____
17. I enjoy taking calculated risks _____
18. I am psychologically "tough" _____
19. I have a great deal of self-confidence _____
20. I can remain cool in a crisis _____
21. I have considerable powers of discernment _____
22. I am quite self-sufficient _____
23. I feel I am a persuasive person _____
24. I feel I can hold my own in any group _____
25. I can give praise easily and with sincerity _____
26. I appreciate constructive criticism _____
27. I am accepted by most people I meet _____
28. I don't feel uncomfortable in a position of authority _____
29. I feel I have a strong personality _____
30. I react quickly and well to an unexpected situation _____