



Catholic Charities Family Services Social History Form

Date: _____ Name: _____

The purpose of this form is to assist your therapist in completing a prompt and thorough assessment in order to create a service plan tailored to the specific needs of the client. Please complete the questions as thoroughly and accurately as possible so that we can provide the most appropriate services for your needs. **This form and all of your records are confidential.**

Please state in your own words your reasons for seeking therapy at this time: _____

If applicable, when did the problem begin, what has contributed to the maintenance, have any solutions helped?

What do you hope to gain from therapy? _____

Issues Checklist

- | | | |
|--|---|---|
| <input type="checkbox"/> Employment issues | <input type="checkbox"/> Risk-taking behavior | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> School issues | <input type="checkbox"/> Generalized dissatisfaction | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Legal issues | <input type="checkbox"/> Guilt | <input type="checkbox"/> Passive behavior |
| <input type="checkbox"/> Financial issues | <input type="checkbox"/> Difficulty being alone | <input type="checkbox"/> Aggressive behavior |
| <input type="checkbox"/> Living arrangements | <input type="checkbox"/> Anxiety that limits activities | <input type="checkbox"/> Unwanted compulsive behavior |
| <input type="checkbox"/> Change in appetite/weight | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Concern about alcohol/drug use |
| <input type="checkbox"/> Unexplainable/uncontrollable crying | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Concern about eating habits |
| <input type="checkbox"/> Extravagance with money | <input type="checkbox"/> Sadness/Depression | <input type="checkbox"/> Previous abuse |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chronic illness | <input type="checkbox"/> Sexual issues |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Worried/nervous | <input type="checkbox"/> Sexual identity concerns |
| <input type="checkbox"/> Frequent lying | <input type="checkbox"/> Shy, uneasy with others | <input type="checkbox"/> Poor concentration |
| | <input type="checkbox"/> Physical concerns | <input type="checkbox"/> Relationship issues _____ |

Marital/Personal Family History

Current marital status: single engaged living together divorced widowed separated

Please give dates if applicable: _____

Spouse/child's name	Gender	Living in home	Age	Occupation	Relationship to you (and description)
Ex. John	M	Yes	45	Sales	Husband - close/distant relationship

Please continue on back if more room needed.

Number and dates of pregnancy loss (miscarriages, stillbirths, abortions): _____

Have there been any major changes for you or a family member in the past two years? (Moves, births, deaths, illnesses) _____

Employment

Please list employment positions, with most recent first:

Dates employed	Position	Employer	Location	Reason for leaving
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Any problems in relationship with people at work? Explain: _____

Medical History

Date of last medical assessment: _____

Major Health issues: _____

Past major illnesses, surgeries, accidents (include dates): _____

Medication taken (including dosage)	Condition treated

Previous and Current Mental Health Treatment

Do you have current thoughts of suicide: Y / N _____

Have you engaged in self-injury Y \ N What type, when: _____

Have you ever attempted suicide? Y / N If yes, how long ago: _____

Outpatient

Provider	Location	Dates	Condition treated	Result

Inpatient

Provider	Location	Dates	Condition treated	Result

Substance Use

Alcohol (frequency) _____ Illicit drugs (including marijuana) _____

Caffeine _____ Tobacco _____ Are you concerned about your substance use? Y / N

Has anyone else expressed concern about your use? Y / N _____

Does any member of your family struggle with the following (please note relation and duration):

Alcoholism/drug abuse: _____

Mental Health issues: _____

Has any relative attempted or committed suicide: _____

Family of Origin

Parent/sibling Gender Age Occupation Relationship to you (and description)
Ex. Jane F 65 Homemaker Mother - close/distant relationship

Parent/sibling	Gender	Age	Occupation	Relationship to you (and description)

Please list any significant family events and dates while growing up (moves, deaths, divorces etc.)

Education

Highest level of education completed: _____

Schools, degrees earned: _____

Any issues with learning? IEP? _____

Private Public Homeschooled

Abuse History

Have you ever experienced any type of abuse: **Y** /**N**

Emotional Physical Sexual Verbal Domestic Violence Neglect Other _____

At what age(s) _____

Resources

Are you open to incorporating your faith in to your therapy sessions? Explain. _____

Religion as a child: _____

Religion as an adult: _____