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MEDICAL SOCIAL HISTORY - ADULT

This form is being completed by: _____

If not client, relationship to client: _____

CLIENT INFORMATION:

Full Name	Social Security Number
Address	Date of Birth, Age, and Place of Birth
City, State, Zip Code	Telephone Number

Ethnicity:

- ☐ (Skip)
- ☐ American Indian
- ☐ Alaskan Native
- ☐ Asian
- ☐ African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White
- ☐ Hispanic
- ☐ Bi-racial
- ☐ Multi-racial
- ☐ Other:_____

Biological Father?
Name: _____
Occupation: _____

Biological Mother?
Name: _____
Occupation: _____

Number of brothers?_____
Number of sisters? _____
Place in birth order (e.g., "second oldest of six children")? _____
Did you move frequently while growing up?

- ☐ Yes
- ☐ No
- ☐ Don't know

What was the highest grade you completed in school?_____
What kind of classes did you attend while in school?

- ☐ All regular classes
- ☐ Regular classes with some Special Ed. classes
- ☐ Special Ed. Classes with some regular classes
- ☐ All Special Ed classes

What best describes the result of your high school education?

- ☐ Regular diploma from high school
- ☐ Adjusted diploma from high school
- ☐ Certificate of attendance from high school
- ☐ GED after leaving school
- ☐ Have not completed high school

How did you do as a student while in school?

- ☐ Very poor
- ☐ Poor
- ☐ Below average
- ☐ Average
- ☐ Above average
- ☐ Excellent

List extra activities you participated in while in school: (Such as clubs, athletics, music. leadership, or social activities):

_____

_____

_____

What education have you attained beyond high school?

- ☐ None
- ☐ Completed some technical/trade courses
- ☐ Received a technical/trade certificate
- ☐ Completed some college courses
- ☐ Received an Associate's Degree
- ☐ Received a professional diploma
- ☐ Received a Bachelor's Degree
- ☐ Received a Master's Degree
- ☐ Received a Doctorate Degree

What is your primary occupation? _____
What other occupations have you had?_____

_____

_____

Have you served in the Armed Forces?

- ☐ Yes
- ☐ No

If "**Yes**" what branch of service? (Check one)

- ☐ Air force
- ☐ Army
- ☐ Coast Guard
- ☐ Marine Corp
- ☐ National Guard
- ☐ Navy

If "**Yes**" how many years served?_____
If "**Yes**" highest rank attained? _____
If "**Yes**" type of discharge? (Check one)

- ☐ Medical Discharge
- ☐ Honorable Discharge
- ☐ Dishonorable Discharge

How long have you lived in this area?_____

Dwelling type? (Check one)

- ☐ Rented apartment
- ☐ Rented home
- ☐ Owned home
- ☐ Mobile home
- ☐ Room in a home
- ☐ Group home
- ☐ Homeless shelter
- ☐ Other

With whom do you now live?_____
Do you receive: (Check all that apply)

- ☐ TANF
- ☐ Welfare
- ☐ Regular Social Security
- ☐ SSI
- ☐ Social Security Disability
- ☐ Medicaid
- ☐ Medicare
- ☐ Food Stamps
- ☐ Alimony
- ☐ Child support
- ☐ Other: Specify:
- ☐ No support received

Are you experiencing physical pain at this time?

- ☐ Yes
- ☐ No

If "**Yes**", continue below, if "No", skip to **Do you have a history of seizures or convulsions?**

What part of your body typically hurts the most?

- ☐ Head
- ☐ Neck
- ☐ Back
- ☐ Stomach
- ☐ Upper limbs
- ☐ Lower limbs
- ☐ Several body areas
- ☐ Entire body
- ☐ Note of the above

How long have you been having these pains?

- ☐ Within the past six months
- ☐ Six months to one year
- ☐ One to two years
- ☐ Two to four years
- ☐ Over four

How severe has the pain been recently?

- ☐ Mild
- ☐ Discomforting
- ☐ Distressing
- ☐ Horrible
- ☐ Beyond description

How often does this pain occur?

- ☐ Monthly
- ☐ Weekly
- ☐ Daily
- ☐ All the time

How often to you take prescribed medications for this pain?

- ☐ Never
- ☐ Seldom
- ☐ Occasionally
- ☐ Often
- ☐ Frequently
- ☐ All the time

Do you use any of the following to reduce the pain?

- ☐ Heat/cold treatment
- ☐ Electrical stimulation or TENS unit
- ☐ Physical therapy or exercises
- ☐ Lie down
- ☐ None of the above

Do you have a history of seizures or convulsions?

- ☐ Yes
- ☐ No

If "Yes" continue, if "No" skip to **Which of the following substances have you used in the past?**

What type of seizures have you experienced?

- ☐ Absence (Petit Mal)
- ☐ Myoclonic
- ☐ Clonic
- ☐ Tonic-Clonic (Grand Mal)
- ☐ Atonic
- ☐ Simple Partial
- ☐ Complex Partial (Temporal Lobe)
- ☐ West Syndrome
- ☐ Lennox-Gastaut Syndrome
- ☐ Status Epilepticus
- ☐ Jacksonian
- ☐ Unclassified Epileptic
- ☐ Other

Approximately what year did your seizures begin? _____

When was your last seizure?

- ☐ Earlier today
- ☐ Yesterday
- ☐ Earlier this week
- ☐ Earlier this month
- ☐ During the past year
- ☐ One to five years ago
- ☐ Six to ten years ago
- ☐ Eleven to fifteen years ago
- ☐ Sixteen to twenty years ago
- ☐ Over twenty years

Do you take medication to control your seizures?

- ☐ Yes
- ☐ No

Which of the following substances have you used in the past? (Check all that apply)

- ☐ Caffeine
- ☐ Alcohol
- ☐ "Designer Drugs"
- ☐ Marijuana
- ☐ Sleeping pills
- ☐ Hallucinogens
- ☐ Amphetamines (meth)
- ☐ Prescription medication (non medical use)
- ☐ Spice
- ☐ Tobacco
- ☐ Steroids
- ☐ Cocaine
- ☐ Heroin
- ☐ Inhalants (huffing)
- ☐ Tranquilizing medications
- ☐ Other substances:
- ☐ None of the listed substances

Which of the following substances do you still use? (Check all that apply)

- ☐ Caffeine
- ☐ Alcohol
- ☐ "Designer Drugs"
- ☐ Marijuana
- ☐ Sleeping pills
- ☐ Hallucinogens
- ☐ Amphetamines (meth)
- ☐ Prescription medication (non medical use)
- ☐ Spice
- ☐ Tobacco
- ☐ Steroids
- ☐ Cocaine
- ☐ Heroin
- ☐ Inhalants (huffing)
- ☐ Tranquilizing medications
- ☐ Other substances: _____
- ☐ None of the listed substances

Have you even been in any alcohol treatment program in the past year?

- ☐ Yes
- ☐ No

Have you ever been in an alcohol or drug abuse self-help group?

- ☐ Yes
- ☐ No

Have you been through any type of drug rehab program in the past year?

- ☐ Yes
- ☐ No

Have you even been in any alcohol treatment program in the past year?

- ☐ Yes
- ☐ No

Are you in any trouble with the law now?

- ☐ Yes
- ☐ No

Have you ever had to spend time in jail?

- ☐ Yes
- ☐ No

Have you ever had to spend time in prison?

- ☐ Yes
- ☐ No

If you answered "Yes" to any of the above <u>three questions</u>, what were the charges or offenses?

_____

_____

_____

GENERAL INFORMATION

MEDICAL HISTORY: List major illnesses and injuries. Provide approximate year of each illness or injury, and treatment received. Provide serious childhood illnesses, injuries, or surgeries.

☐ Check here if this does not apply because you have never had major illness or injury.

YEAR	HEALTH PROBLEM	TREATMENT RECEIVED

PSYCHIATRIC HISTORY: List psychiatric illnesses and mental health treatment.

☐ Check here if this does not apply because you have never had mental health treatment.

YEAR	TYPE OF PROBLEM	TREATMENT RECEIVED

CURRENT PRESCRIPTION MEDICATIONS: List all prescription medications you are currently taking.

☐ Check here if this does not apply because you are not taking prescription medications.

MEDICATION	PRESCRIBED BY	REASON FOR MEDICATION

RELATIONSHIP HISTORY: Give approximate year of any marriages and divorces and indicate whether any marriage was terminated by death of spouse. Also, indicate spouse's occupation and the names and ages of children born from the relationship.

☐ Check here if this does not apply because you have no relationship history.

YEAR	RELATIONAL CHANGE	RELATIONSHIP INFORMATION

WORK HISTORY: Describe your work history.

☐ Check here if this does not apply because you have no work history.

FROM YEAR	TO YEAR	WORK INFORMATION

DAILY ACTIVITY – ADULT

We understand your condition may limit some of the things you can do. Answer the following questions to help us understand what you can do in your present condition.

Are you working at this time?

☐ Yes
☐ No

If "No" continue below, if "Yes" skip to **Social Activities.**

Can you work at all now?

☐ Yes
☐ No
☐ Part-time only
☐ Housework or home maintenance only.
Comment, if desired: _____

Have you been applying for work?

☐ Yes
☐ No
☐ Was applying, but gave up trying.
Comment, if desired: _____

Do you plan to return to work?

☐ Yes
☐ Yes, within a year
☐ No
Comment, if desired: _____

Social Activities:

☐ I talk with family members nearly every day
☐ I talk with friends and neighbors fairly often
☐ I can use a phone to call family and friends
☐ I often go out to eat with family and friends
☐ I occasionally go out to eat with family and friends
☐ I often correspond using letters, emails or texting
☐ I occasionally correspond using letters, email or texting
☐ I attend church
☐ None of the above

I engage in recreational activities, including:

☐ Shopping
☐ Walking
☐ Running
☐ Swimming
☐ Visiting at friend's house
☐ Going to movies
☐ Having friends over
☐ Watching TV
☐ Listening to music
☐ Travel – to where:_____
☐ Playing cards or games
☐ Other (specify):_____
☐ None of the listed activities

I do the following chores around the house: (If you need help doing a chore, also place an "**" to the left of the check box.)

☐ Cooking
☐ Washing dishes
☐ Vacuuming
☐ Laundry
☐ Watering the lawn
☐ Mowing the lawn
☐ Gardening
☐ Taking care of pets
☐ Taking care of children
☐ Taking care of adults
☐ None of the listed chores

When I go out, I travel by:

☐ Drive my own car
☐ Drive a borrowed car
☐ Having another person drive me in a car
☐ Taking a bus
☐ Taking a cab
☐ Walking
☐ Bicycling
☐ If other, explain:_____
☐ None of the above

Shopping and money management:

- ☐ I do my own shopping
- ☐ I go shopping, but need the help of another person
- ☐ I cannot go shopping at all
- ☐ I make my own shopping list
- ☐ I can pay the right amount and count the change
- ☐ I handle my own money
- ☐ I have someone who helps me handle money
- ☐ I keep a checkbook and write checks

Care of self:

- ☐ I can bathe myself in the tub
- ☐ I can bathe myself in the shower
- ☐ I can dress my self
- ☐ I can take care of my hair
- ☐ I can take care of my clothing
- ☐ None of the above

Understanding and Remembering:

- ☐ I can concentrate on a task until I finish it
- ☐ I understand and remember what I read
- ☐ I understand and remember programs I see on TV
- ☐ None of the above

My interests and activities still include:

- ☐ None of the activities listed below
- ☐ Reading
- ☐ Conversation
- ☐ Keeping up with the news
- ☐ Hobbies, including _____
- ☐ Crafts, including _____
- ☐ Family activities
- ☐ Enjoying friends
- ☐ Physical exercise

I wake up around: _____

Do you wake up on your own?

- ☐ Yes
- ☐ No

If no how do you wake up? _____

Morning activities (6:00 a.m. to noon):_____

_____

_____

At lunchtime, I:_____

_____

_____

Afternoon activities (1:00 p.m. to 6:00 p.m.): _____

_____

_____

Evening activities (6:00 p.m. to bedtime): _____

_____

_____

I go to bed at: _____

Describe your quality of sleep: _____

_____

_____

_____

Do you take medication to help you sleep?:

- ☐ Yes
- ☐ No

If yes what kind of medication?:_____

Do you require assistance to fall asleep?:

- ☐ Yes
- ☐ No

If yes what type?: _____

ACKNOWLEDGEMENT:

I _____ acknowledge that the above information has been completed truthfully and accurately to the best of my ability.

_____	_____	_____
Printed Name of Client	Signature of Client	Date
_____	_____	_____
Printed Name of Person Completing Form	Signature of Person Completing Form	Date