Scottsdale
Mental Health & Wellness
INSTITUTE

Social History/Assessment

Client Name: ________________________________ **DOB:** ____________________ **Date:** _________________

Referral Agency: ____________________________ **DUI Date:** _______________ **Case #:** ______________

Do you have any legal charges pending? ☐ Yes ☐ No If yes, explain why: ____
Are you on probation now? ☐ Yes ☐ No If yes, explain why: ____
Probation/Parole officer name: ____ Phone #: ____________________________
Have you ever been in prison? ☐ Yes ☐ No If yes, when:_________ why:______________________ how long:__________

Please list all arrests, legal charges, including DUIs, assault, disorderly conduct, etc. approximate dates, including the current charge:

Charge	Date	Charge	Date

Please list all counseling or treatment:

Name of facility/ City/State	Counselor name	Length of time & year	Reason

Have you ever been under psychiatric care? ☐ Yes ☐ No
If yes, explain:

Have you ever thought of or planned a suicide? ☐ Yes ☐ No Have you ever attempted suicide? ☐ Yes ☐ No
If yes, explain:

Do you currently have thoughts about suicide?- -☐ Yes ☐ No
Has a family member ever committed suicide?- -☐ Yes ☐ No
Check any of the following behaviors that have recently applied to you:

☐ Change in sleep patterns ☐ Crying ☐ Withdrawal or isolation
☐ Change in eating pattern ☐ Anger outbursts ☐ Loss of concentration

How old were you when you had your first drink? ____________________ When you first got drunk?________________
How old were you when you first used a mood-altering drug? ______ Do you think you're an alcoholic?_____addict?
When was your last drink? ____________________________ Last time you got drunk? __________________________

What was your drinking pattern like?

Alcohol Use History:	How often?	How many drinks?	Type of drink?
Age ____ to 20			
Age 21 to 29			
Age 30 to 39			
Age 40 to 49			
Age 50+			

What has your drinking pattern been like for the last 6 months: ____

Check drugs used (even if only one time):

☐ Amphetamines ☐ Hallucinogens ☐ Oxycontin ☐ Spice ☐ Gasoline

☐ Methamphetamines ☐ Ecstasy ☐ Hydrocodone ☐ Bath Salts ☐ Other ____________

☐ Cocaine ☐ Heroin ☐ Valium ☐ Soma

☐ Crack ☐ Morphine ☐ Xanax ☐ PCP

☐ Marijuana ☐ Methadone ☐ Klonopin ☐ Paint

☐ Hash ☐ Suboxone ☐ Ambien ☐ Glue

What is or was your drug of addiction? ____________________________________ Date of last use: ____________

Heaviest period of use (age or years): ____

Have you ever overdosed?- - - - - - - - - ☐ Yes ☐ No Have you ever sold drugs?- - - - - - - - - - - - - - - - ☐ Yes ☐ No

Have you ever attended a 12 Step program?- - - - ☐ Yes ☐ No Was it Court ordered?- - - - - - - - - - - - ☐ Yes ☐ No

Are you attending now?- -☐ Yes ☐ No

How often do/did you attend? ________________________ Do/did you have a sponsor?- - - - - - - - - - - ☐ Yes ☐ No

Which step are you on or have you completed? ____

Other addictions (smoking, gambling, sex, eating disorders, etc.): ____

Have you ever had blackouts (periods where you couldn't remember what you said or did)?- - - - - - - - - - - -☐ Yes ☐ No

If yes, explain:

Did/Do you sometimes drink or use drugs when alone?- ☐ Yes ☐ No

Did/Do you sometimes drink rapidly at the beginning of a drinking episode?- ☐ Yes ☐ No

Did/Do you ever sneak a drink, hide bottles, hide drugs, or deny using?- ☐ Yes ☐ No

Are you always able to stop drinking/using drugs once you start?- ☐ Yes ☐ No

Does it take more alcohol/drugs to get the same desired effect as it did in the past?- - - - - - - - - - - - - - - - -☐ Yes ☐ No

Have you ever used more alcohol or drugs than you intended?- -☐ Yes ☐ No

Have you ever used alcohol/drugs to make you feel better emotionally?- ☐ Yes ☐ No

If yes, explain:

Have you ever used alcohol/drugs to help with physical pain?- ☐ Yes ☐ No

If yes, explain:

Have you ever experienced: Shakes, Tremors, Convulsions, Hallucinations, Seizures?- - - - - - - - - - - - - - ☐ Yes ☐ No
Have you ever felt you should cut down on your drinking/drug use?- ☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking/drug use?- -☐ Yes ☐ No
Have people annoyed you by criticizing your drinking or drug use?- -☐ Yes ☐ No
Have you ever had a drink first thing in the morning to steady your nerves/get rid of a hangover?- - - - - - - - ☐ Yes ☐ No
Have you ever attempted to change your drinking or using pattern in order to decrease its effects or to gain better control of your use? (e.g. drinking on weekends, only drink beer now)

If yes, explain:

Have you lost friends due to alcohol or drug use?- -☐ Yes ☐ No
Have you ever done acts or behaviors you would not have done if sober?- ☐ Yes ☐ No
Does your personality change when you have been drinking/using drugs?- ☐ Yes ☐ No

If yes, explain:

Counselor Notes:

Counselor Signature/Credentials ***	Printed Counselor Name	Date Signed

*** My signature verifies that I have reviewed all information provided on this document with the client.