Shorehaven Behavioral Health, Inc - Family History

Name:_________________________________ Date:_____/_____/_____ Therapist:________________

Instructions: Your therapist would like each adult in the family to answer these questions. This will help him or her better understand your situation and problems.

Names of all who reside in household:____
____

In case of an emergency, name and telephone number of your nearest relative:
____ Telephone:____________________

Who referred you?/How did you hear about us?____

PSYCHOLOGICAL HISTORY

A. What problem(s) caused you to seek help? ____
____

B. Check if you have had any of these problems or symptoms recently:

___ Anxiety	___ Changes or problems in eating	___ Headaches	___ Nervousness
___ Tearfulness/crying	___ Changes or problems in sleeping	___ Fatigue/tiredness	___ Drinking/drugs
___ Chronic pain	___ Sexual difficulties	___ Nightmares	___ Dizziness
___ Depression	___ Difficulty concentrating	___ Irritable	___ Panic
___ Sadness	___ Lost interest in usual activities	___ Gambling problems	___ Withdrawal
___ Pounding heart	___ Other: ___________________________		

___ Fears (circle): dying going crazy crowds public speaking other:______________

C. Have there been any recent **illnesses or deaths** among your family or close friends? ___ Yes ___ No

D. Have there been any recent **crises** or **major changes** in your life? ___ Yes ___ No

E. Have you ever experienced any emotional, physical, or sexual **abuse**? ___ Yes ___ No

F. Have you ever intentionally hurt yourself or made a **suicide attempt**? ___ Yes ___ No

G. List any **medications** for anxiety, depression, sleep, or emotional conditions that you have taken now or in the past. List them:

H. Have you been in counseling or psychotherapy or had treatment from a psychiatrist before? ___ Yes ___ No
When and with whom:

I. Have you had any hospitalization(s) for emotional problems? ___ Yes ___ No
When and where:

J. Please name any people or organizations that provide help and support to your family: ________________
____

MEDICAL HISTORY

A. List any current medical conditions and disabilities:
____

B. List ANY medications you are taking for any medical conditions.

C. List past medical conditions (include any surgeries):____
____

D. Name of your physician(s) and their telephone number(s) and address(es): ___________________________
____

E. Have you had a medical exam within the past year? ___ Yes ___ No
Findings:

F. Indicate anyone in the family who has had these problems:

Problem	Who	Problem	Who	Problem	Who
Allergies to Medications:		Diabetes	____________________	Seizures	______________________
		Emphysema	________________	Sexual difficulties	_________________
Allergies	__________________	Eye/ear/vision	_______________	Sexually transmitted disease	_______
Anemia	___________________	Fatigue	____________________	Skin problems	_________________
Arthritis	___________________	Head injuries	_______________	Speech/language	_________________
Asthma	___________________	Headaches	_________________	Thyroid	______________________
Back problems	______________	Heart problems	_____________	Other (e.g. genetic):	
Bowel problems	______________	Kidney problems	_____________		
Cancer	___________________	Liver problems	______________	Any *Disabilities*	_____________
High blood pressure	_________	Neurological problem	__________		
Chronic pain	________________	OB/GYN problems	____________		
Constipation	________________	PMS	______________________		

Please complete the other side-

DRUG AND ALCOHOL USE

A. Please describe the drug and alcohol use of your family. Use the number which best states how often each person uses each drug. For your children, please write in the name of the child at the top of the column.
Use the number which best states how often each person uses each drug.
0 = Never or less than once a month, 2 =weekends only, 3 = up to 10 days a month 4 = 11-20 days a month, 5= daily or almost daily, 6 = used in past, not using now. If you view this pattern as a problem, *circle the number.*

Who	Beer/Wine/ Liquor	Nicotine	Marijuana	Crack/ Cocaine	Inhalants/ Huffing	Speed/ Ecstacy/ Amphetamines	Opiates/Pain meds/Oxy/ Vicodin/Downers	LSD, over-the-counter meds, others
Self								
Partner/ Spouse								
Father								
Mother								
Sibling								
Other:Who? __________								

B. Are you **concerned** about your drug or alcohol use? ___ Yes ___ No
C. Is someone who cares about you concerned about your use of drugs or alcohol? ___ Yes ___ No
D. Do you get angry when others criticize your use of drugs or alcohol? ___ Yes ___ No
E. Do you ever feel **guilty** about your use of drugs or alcohol? ___ Yes ___ No
F. Are you concerned about the drug or alcohol use of someone in your family? ___ Yes ___ No
G. Did you grow up in a home in which a parent abused drugs or alcohol? ___ Yes ___ No
H. Age at first drink? _______________________ Age of first use of other drugs?______________________
I. Which of these reasons for drinking apply to you? (circle) Relieve stress Escape pain Lower inhibitions To be sociable To go along with others To get high Like the taste Reduce tension before flying or meetings Relaxation Other:

LEGAL PROBLEMS

A. Have you ever been arrested (including OWI/DUI)? ___ Yes ___ No
B. Have you ever been involved with Protective Services? ___ Yes ___ No
C. Please list other legal problems:

SCHOOL AND WORK HISTORY

A. Are you currently enrolled in school? ___ Yes ___ No
B. Highest grade completed? ____________________________
C. If you are in school, what field are you studying and which school? __________________________________
D. Your occupation(s): ____
E. Length of time at current job? ____________________
What *strengths do you feel will enable you to help resolve problems* you may have:

What experiences, needs, or difficulties have you had which do or may pose challenges?

What family and community supports and resources are available to help you?

Please tell us about any lifestyle or family values, including religious values, which affect you positively or negatively or which we should know about?

Lastly, please tell us about your recovery? For instance, What would you like to see happen? What are the priorities for changes? What are the recovery goals?