PSYCHOSOCIAL HISTORY—ADULT
INSTRUCTIONS
Rev 2/4/14

The psychosocial history is perhaps the single most important data-capturing tool to facilitate effective therapeutic intervention. The psychosocial history, in conjunction with test data and collateral materials serves as the basis for the establishment of the diagnostic assessment, which guides all future treatment. Positive therapeutic outcome is significantly compromised in the absence of a complete psychosocial history.

Prior to initiating the psychosocial history, it is important to clarify the nature of the assessment. For example, is the assessment simply being conducted as a prelude to ongoing therapy, or is it being conducted to facilitate a more formal report? If it is being utilized to facilitate treatment, it is important to recognize that the diagnostic assessment is, in fact, a prelude to treatment as opposed to being treatment in and of itself. That is, it is important to create and maintain clinical neutrality during the diagnostic assessment in order to ensure a thorough capture of the data necessary in order to create an appropriate clinical formulation and treatment plan. Often, clinicians tend to jump towards providing treatment prior to capturing all of the necessary data, leading to an inadequate diagnostic assessment and subsequent poor therapeutic outcome.

If the psychosocial history is being conducted as part of a formal evaluation procedure, it is important to clarify the specific referral questions, identify who the "client" is for the assessment, and understand the context in which the information obtained will be utilized.

Prior to initiating any diagnostic assessment session, it is important to clarify the nature of the assessment, the limits of confidentiality, and any other factors that might impact the assessor/subject relationship. It is important that the clients be afforded the opportunity to raise questions regarding the purpose of the assessment, and to fully assert their rights relative to the assessment procedure.

The psychosocial history form is a tool to facilitate efficient data capture. It is specifically designed to facilitate a quality clinical interview. The initial questions are relatively emotionally safe, progressing towards more emotionally threatening content, and eventually completing with relatively emotionally neutral items. This design is intended to help clients feel safe, leading to more complete discloser.

A skilled clinician recognizes that the items on the psychosocial form are simply prompts for inquiry and should not be viewed as an exhaustive list of questions that should be answered. The following guidelines are offered to assist clinicians in recognizing the range of further inquiry that should be pursued for each of the items listed in the psychosocial history form and will also assist clinicians in recognizing the most effective method for capturing accurate clinical information. These guidelines, again, do not substitute for clinical skills. For example, the ability to maintain a rapid but empathic

pace to the clinical interview often is as important in securing good clinical data as is the ability to ask the "correct" question.

The psychosocial history form, as noted previously, is simply a tool to facilitate the clinical interview. It is appropriate to write on the back of the form, in margins, and to attach additional pages as necessary. The psychosocial history form is a "working document", and should not be considered a document to be shared in a public form. However, it is equally important to recognize that all work documents may be subject to review of others, and therefore care must be taken in ensuring that only clinically appropriate information is recorded on the form and that the source of the information be clearly attributed to its reporter. In conducting psychosocial histories, it is often helpful to use multiple colored pens to denote who is providing the information. For example, information obtained from the subject may be recorded in black, while information obtained from a parent, significant other, or caseworker may be recorded in red. If this technique is utilized, a legend should be noted on the psychosocial history form clarifying the meaning of various colors. Otherwise, the information obtained on the psychosocial history form is presumed to have been provided by the subject of the assessment. In most cases, the vast majority of the information on the psychosocial history should be captured directly from the subject of the interview, with no one else present during the interview.

Although the psychosocial history form should be viewed as a tool for facilitating the clinical interview, it is important that all of the items listed on the form be explored with the subject of the assessment. At the completion of the assessment, there should be no blanks left on the form.

The Psychosocial History is only one component of a sound assessment. Assessment should also include documentation from other sources, such as schools, court personnel, prior treatment providers, etc. Additionally, testing is also usually important as part of the assessment process. Good assessment synthesizes these various data sources into a complete and coherent picture of the subject's functioning and capacity.

The following headings represent the items on the Psychosocial Intake Form, and clarification of what materials should be gathered and in some cases, suggestions as to how the material might be captured.

Therapist: Record the name of the person who is conducting the assessment.

Date/Time: Enter the date that the assessment is being conducted. It is often useful to clarify the specific time intervals that each of the participants in the assessment is engaged in the interview. For example, if a caseworker is initially interviewed prior to meeting with a subject, the amount of time spent with the caseworker is recorded, then the amount of time spent with the subject is recorded, and then the amount of time spent with the subject and caseworker together is recorded.

Client Name: Enter the subject's entire name, placing in quotes the name that the person prefers to be called. Make sure that the client spells their name for clarification.

Case #: Enter the subject's MOPS generated case number.

Date of Birth: Enter the client's date of birth. If they do not know their date of birth (or any other information that they don't know), note this on the form.

Age: Enter the subject's current age.

Race/Ethnic: Enter the subject's self-described race/ethnicity.

County of Residence: Enter the county of residence as defied by the MACSIS standards. Fro example, if the subject is placed in Fairfield County by Franklin County, the technical county of residence would be Franklin County.

Social Security Number: Enter the subject's SSN.

Phone #: Enter the subject phone numbers; identify each as home, cell, or work.

Permanent Address: Enter the subject's address.

Emergency Contact: Enter the name and phone number of the subject's next of kin, in addition to their relationship.

Case Manager: Enter the name and agency of any case managers that might be involved in a particular case. This includes Children Services case managers, mental health case managers, and MR/DD case managers.

Legal Status/Guardian: Enter the name and relationship of the legal guardian, probation officer, or parole officer. Indicate the county of jurisdiction, and the phone number of the contact person.

Attorney: Enter the name of attorney associated with any ongoing court case involving the subject of the evaluation.

Referral Source: Enter the name and role of the person who referred the subject for the assessment.

Stated Problem: Enter the understood reason that the person has been referred for assessment. This typically can be taken from the phone intake or psychosocial history self-report form. Indicate symptoms, duration, severity, and frequency.

Family & Social Information

Marital Status: Identify whether the subject is never married, married, divorced, separated, or widowed; and the length of time.

Number of Marriages: Identify the number of times the subject has been married, length of the marriages, and reasons for terminating the relationship if applicable.

Marital Relationship: Explore the quality of the marital relationship and the subject's satisfaction with the relationship. "How would you describe your relationship with _____?" "What is the best part of this marriage?" "What is the worst part of this marriage?"

Other Romantic Relationships: Explore the client's relationship history. Gather information regarding the names and current ages of romantic partners, when the relationship began, length of relationship, quality of relationship, and reason for terminating the relationship. It is important to ask if the client has children with each romantic partner.

Children (Names/Relationship/Age): Identify the number of children the subject has--noting the names, ages, relationship and parents of the children. Also note each child's current placement.

Current Living Condition/Household Composition: Identify with whom the subject currently resides. Include all persons who live in the home, their ages, and the quality of the relationship the subject has with these individuals. Identify the specific living arrangements including the general geographical makeup of the home (rural, urban, population density, access to neighbors, etc.), and their overall perception of their current living situation.

Current CPS Involvement: Identify Child Protective Services' involvement include case worker's name and current case plan goals.

Family of Origin: To gather information regarding the subject's family of origin it is often helpful to have the subject describe the chronology of their living arrangements from birth until the present time. Have the subject identify where they were born, whom they lived with at each age, why placement transitions occurred, and how they felt about each of the transitions.

Typically, questions regarding the quality of their parents' relationship should also be explored. Specifically, whether their parents are still married, the client's age when their parents separated, and why their parents separated should be explored. It is often helpful to question what the "best" quality of their family of origin was and the "worst" quality of their family of origin. This can often be explored through questions such as, "What was the best thing about living with your mom?" Have the subject describe their current relationship with their parents.

Also, have the subject identify any other persons who may have lived in their home and when those other persons lived in the home.

Siblings: Have the subject identify the name and age of each of their siblings. Also attempt to have the subject clarify the specific relationship of their siblings (biological, half-sibling by which parent, step-sibling by which parent, or adoptive/foster sibling). Identify the quality of their relationship with each of their siblings.

Support System: Have the subject respond to the following question: "Out of everyone in the whole world, who do you count on the most?" Then have the subject identify whom they count on second. Explore the quality of the relationship with these individuals, their ongoing access to these individuals, and any negative impact that these relationships may have on the subject (ie. Criminal activity/substance abuse).

Friends: Have the subject identify "How many best friends do you have?" Explore with the subject how they actually utilize their friends (i.e., does the best friend know about the situation that brings the subject to treatment at this time?).

Community Interest/Involvement: Have the subject identify any community activities that they participate in, such as volunteering, community recreation programs, or other social/community organizations.

Religious/Spiritual Involvement: Identify their involvement with any worship experiences. Identify their religious affiliation, including the specific denomination. Identify how often they attend worship services or other religious activities, and with whom they attend these services. How has their involvement with religious activities changed during the course of their lives?

Ethnicity/Diversity/Discrimination Impact: "Has there ever been a time that you felt you have been treated differently because of how you look or who you are?" Identify any significant impact because of racial, ethnic affiliation, sexual orientation or history of discrimination.

Legal System Involvement: Identify any previous involvement with the criminal justice system. In many cases, it is helpful to create a chronology of these events, identifying the first involvement with the criminal justice system as well as any sequel events. Identify the sanctions associated with each identified offense, and what jurisdiction the offense occurred within. This needs to be queried with sentences such as: "When was the first time you got in trouble with the law?" "What did you do to get in trouble?" "What happened as a result of this involvement?" Attempt to differentiate juvenile offenses and adult offenses. When possible, court records should be confirmed from the internet or through a release of information from the relevant jurisdiction.

Other Criminal Behaviors: Have you ever done something that you could have or should have gotten into legal trouble for, but did not receive legal charges? –such as a

physical fight, domestic violence, drinking and driving, or engaging in sexual activities with someone under age or who didn't consent"

Interests/Hobbies: Identify "What do you do for fun?"

Educational/Occupational History:

Highest Level of Education: Identify the grade that the subject has successfully completed. If they attended college, clarify what their major was and their academic status (AA/BA/MS, etc.) If they did not complete their academic degree, why not?

Location: Identify the city or the school board area with which the school is associated.

Special Classes/Retentions/Training/GPA: Identify if they have participated in any Special Education programs. Identify the specific form of Special Education programming (SBH, ED, MH, Reading Resource Room, etc.), and identify during which school years they participated in this specialized academic environment. Identify how their grades have been impacted as a result of their participation in specialized educational programming. Identify if they have ever been academically retained. Identify if they have ever been involved with any specialized training or vocational training. Identify what kinds of grades they typically earned, and if possible have them identify their grade-point average.

Behavioral Problems While in School: "Have you ever had detentions, suspensions, or expulsions?" Identify why and when they have had these difficulties.

Extracurricular: "Did you ever participate in extracurricular activities, such as sports, choir, band, or other school activities?" Identify the grades of involvement for each activity.

Current Occupation/Means of Support: Identify the subject current employment status, or how they support themselves if unemployed (e.g., SSI, SSDI, Retirement, Unemployment). What specifically do they do for their current employer?

Employment History: Identify age of first job and nature of jobs the subject has held. "Have you ever had a job?" "Whom did you work for?" "Why did the job end?" "What was the best/worst part of this job?" "Have you ever been fired or asked to resign?" Identify the reasons for termination, if any. If the subject is unemployed ask, "When did you last work?"

Military/Discharge Type: Identify branch, dates of service, deployments, and type of discharge.

Other Sources of Income: Identify if the subject is receiving other sources of income to support them in their existence.

Gross Weekly Income: Identify how much they make each week/month. Clarify what other income is available for the family and the source of that income.

History of Victimization:

In this section, it is not appropriate to ask **whether** somebody has been victimized, but rather, ask the subject to identify specific behaviors that they may have experienced. It is important to explore abuse during childhood and adulthood. If any victimization is identified that has not been previously reported, you must follow the agency policy and report the victimization to the appropriate agency.

Physical Abuse: "When you were a kid, did any adult ever hit you for any reason?" If the subject indicates they have experienced corporal punishment, clarify the frequency, intensity, and reason for the reported corporal punishment. Specifically identify if any marks were ever left on their body as a result of being hit. Identify the name of each of the persons who have physically hit them, when it occurred, and identify whether it has previously been reported. For physical abuse in adulthood, also identify whether the subject continues to have contact with their abuser, and if an order or protection order is in place.

Sexual Abuse: "Has any person ever touched you on your private parts?" "Has any older kid ever touched you on your private parts?" If either of these questions are answered in the affirmative, or any data is obtained suggesting that they have been forced to touch an adult in a sexual fashion when they were a child, clarify who the individual was, when it occurred, how often it occurred, the exact nature of this sexual contact, and whether it was ever reported. "As an adult, has anyone ever touched you in an uninvited fashion?"

Mental Abuse: "Has any person ever called you bad names, made fun of you, or put you down?" Again, clarify who, the frequency, when it occurred, and whether this behavior has been reported to the appropriate authorities.

Neglect: "Did you always have food, clothes, a place to stay, and somebody to watch you when you were a kid?" Clarify whether they have had simply older siblings supervising them who may/may not have been appropriate monitors.

Domestic Violence: Identify a history of victim of domestic violence or witness to domestic violence. "Do people in your family hit each other or yell at each other in an abusive way?" If so, "Describe this."

CSP Involvement: Identify when Child Protective Services first became involved with the subject's family of origin, why, and who specifically was involved in the case.

If multiple incidents of Children Services involvement are reported, identify each of them separately.

History of Potentially Abusive Behavior

For each of these items, it is important to make a presumption that the subject has engaged in the behavior. That is, it is appropriate to ask, "How often do you…?" as opposed to "Have you ever…?" For each of the substances listed, ask the subject, "How often have you used" the substance. If the answer is anything other than "never," identify when the subject first used the substance (onset—when, how much and length of use), how often they are currently using the substance (when do they use, how much and length of use), at its highest frequency how often they used the substance including the most they have used in a time period, when they began using this amount, how much they use and length of use , and when they last used/most recent the substance (when and how much). It is also important to ask questions to clarify whether the subject ever experienced tolerance and/or withdrawal to the substance or any negative repercussions (medical or legal consequences) as a result of their usage of each of the substances. Ask about EACH substance!

It is often helpful to provide alternative names to each of the substances to help the subject more clearly identify whether they have used the substance. For example, when questioning regarding the use of marijuana, it is appropriate to ask how often they have used "pot" or "weed." Cocaine includes both "crack," "rock," or other forms of cocaine. Depressants include "downers," or "things that make you tired." Amphetamines include "uppers," "Ritalin," "Adderall," "Meth," or "things that help keep you awake." Hallucinogens include "shrooms," "acid," "LSD," "salvia,"or "peyote." Opioids include "Oxy," "morphine," "heroin," or "other pain medications." Inhalants include "huffing gas," "sniffing glue," "dusting," or "doing rush, poppers, locker room, whippets," or "other things that you sniff." Identify if they have used any other substances that do not meet the above classifications. This includes substances such as "Ecstasy." Also, identify their frequency of use of tobacco or chewing tobacco. For caffeine, identify how often they consume caffeinated beverages, as well as consume caffeine pills.

Additionally assess whether they have participated in distribution or manufacturing of any illicit substances.

Toxicology Screens: Does anyone require you to submit drug screens? Who is requiring you to screen? Where are you screening? How often are you screening and what days? Are your screens random or scheduled? How many positive screens have you had? How many negative screens have you had? How many have you missed or no call screens?

Sexual Activity: Identify how many people they have had sexual intercourse with. If they have engaged in intercourse, clarify the nature of the relationship (boyfriend/girlfriend or one night stand), how often they have engaged in this

behavior, whether they used contraception, safe-sex methods, and have ever impregnated.

History of Prostitution: Identify whether they have ever utilized a prostitute or prostituted. If the subject has significant sexuality issues, it may be appropriate to gather a more complete sexual history utilizing the *Sexual History Form*.

History of Pathological Gambling: Identify whether they have engaged in gambling behavior, what is the most they have ever lost, what is the most they have ever won, and whether they have ever lost more than they could afford to lose at the time. Also clarify the frequency of their gambling behavior.

History of Abusive Eating Behaviors: Identify whether they have any pathological eating behavior. This includes engaging in overeating, under eating, or purging. If they have engaged in any of these behaviors, clarify whether they have any distortions of their perception of their body.

Substance Abuse in Significant Relationships: Identify if the subject has been involved in a significant relationship with a person who abused drugs or alcohol.

Substance Abuse in Family History: Identify whether any of their parental figures or other significant family members have engaged in chronic substance abuse. Specifically, ask, "Do either of your parents use drugs or alcohol?" Clarify the frequency of their utilization of these substances, as well as the potential impact that their use has had on the subject. Attempt to clarify whether they continue to use these substances, or whether this simply was an historical event.

Mental Health/AOD Treatment History:

Counseling: Ask the subject, "Have you ever seen a psychologist, psychiatrist, or counselor of any sort?" If the subject has engaged in previous treatment services, clarify where they received services,

Previous Treatment Goals: What the primary treatment goals included, when they engaged in these treatment services, and what either worked or did not work during the course of treatment. A release of information should be sent to ALL prior treatment providers.

Previous Diagnoses: Identify whether the subject has any awareness of any previous diagnoses that have been attributed to them. What situations led them to have the diagnosis?

Previous Psychotropic Medications/Efficacy: Identify what medications they have taken in the past, if they had any side effects to the medications, why they took them, and how effective the medications were.

Psychiatric Hospitalizations/Reasons: "Have you ever been in a psychiatric hospital of any sort?" If so, clarify when they were hospitalized, why they were hospitalized, how long they were hospitalized, and the outcome of the hospitalization.

Bizarre Ideation History: "Have you ever heard voices, or seen things that aren't really there?" It is somewhat normative for individuals to describe unusual perceptual experiences, including seeing amorphous objects in the periphery of vision (illusions), or hearing their voice being called. Even if the subject describes relatively normative distorted perceptual experiences, it is important to clarify the nature of these perceptual experiences including when they occurred, what precipitated their occurring, the frequency that they occur, and their response to these perceptual experiences.

Suicide: Have you ever thought of hurting yourself?" In most cases, individuals have at least thought of hurting themselves. If they say no, query further so that the subject fully asserts that they have not had these experiences.

Self-Mutilation: Indicate if they have participated in any self-mutilation behavior. Note if the mutilation required medical treatment. "Have you ever cut yourself or hurt yourself on purpose?"

Homicide: " "Have you ever thought of hurting somebody else?" . If they report that they have had suicidal/homicidal ideation, clarify when this occurred, what precipitated the feeling/behavior, how they responded to the feelings, and what prevented them from being successful in carrying out the behavior. It is important to clarify these dynamics for each episode of suicidal/homicidal ideation.

Current AOD Treatment: If they are currently receiving substance abuse treatment services, clarify who the provider is, why they are engaging in these services, and their level of involvement in the treatment services. Clarify if they are attending AA/NA as well.

AOD Treatment Episodes: Identify the number of Outpatient, Residential, and Rehab treatments the subject has received.

Past AOD Treatment: Identify the timeframe and specific providers of these services.

Program of Recovery: Clarify how they define their "program of recovery" and identify specific mechanisms that they are engaged in to maintain sobriety.

Family Mental Health History: "Has anybody else in your family ever received mental health or substance abuse treatment services?" If so, clarify whom, why, when, and how this may have impacted the subject.

Medical Status:

Primary Care Physician: "Who is your primary care doctor?" If they do not have a primary care physician, identify where they generally receive their medical care. Get as much information on who there physician is, so that a release of information can be sent to them.

Current Problems: "Do you currently have any medical problems?" Attempt to clarify whether the condition identified is chronic or acute. Identify what services they have received to treat the condition, if any.

Current Medications: Have the subject identify each medication they are currently receiving, as well as the purpose of receiving the medication. Often, the subject will simply say they are taking medications and do not know what they are. Attempt to have them take their best guess as to what medications they are taking and why. If they are receiving medications, have the subject identify whether they believe the medications are helpful for them.

Personal Medical History: "Have you had any other medical problems in the past—broken bones/ stitches/ surgeries?"

Hospitalizations: "Have you ever been hospitalized overnight for any reason?" Clarify the nature of these hospitalizations, when they occurred, and any significant response to the hospitalization.

History of Brain Trauma: "Have you ever been hit in the head or knocked out?" If so, "Do you have any long-term problems as a result of this head injury?" If answered in the affirmative, clarify when the injury occurred, how it occurred, and what level of medical attention occurred.

Developmental Problems: "Did you walk, talk, and do other things at about the same time the other kids did?"

Sleep Patterns: "What time do you generally go to bed?" "What time do you get up?" "Do you have any difficulties getting to sleep?" "Do you have any problems staying asleep?" "Do you ever have nightmares?" Identify if this sleep pattern has been stable over the last several months or if there are changes in their sleep pattern.

Eating Patterns: "How many meals a day do you eat?" "How many snacks do you eat a day?"

Weight Maintenance: "Has your weight gone up, gone down or been relatively stable over the last six months?" Attempt to clarify the quality of the meals they are getting (junk food or a well balanced diet).

Aids in Daily Living Limitations: "Do you wear glasses, false teeth, or have any other things to help you get by day-to-day?"

Activities of Daily Living: "Do you have difficulty getting things done around the house; shopping, cleaning, paying bills, fixing meals?" Identify who helps the subject complete these tasks and to what degree (supervision and oversight or completing it for the subject). If the subject has significant adaptive living skills issues, it may be appropriate to gather a more information utilizing the *Activities of Daily Living Assessment*.

Family Medical History: "Has anybody else in your family had significant medical problems?" If so, clarify the nature of the medical difficulties, the chronicity of the medical difficulties, and how the medical difficulties may have impacted the subject.

Cognitive/Behavioral Functioning:

This portion of the psychosocial history is essentially a mental status examination. If significant mental health conditions are believed to be present, it may be appropriate to utilize the more fully developed mental status examination form as opposed to the abbreviated mental status examination included in the psychosocial history.

Height/Weight: "How tall are you?" "How much do you weigh?" It is often important to contrast these perceptions of height and weight to physical measurements.

Appearance: Describe the subject's general physical appearance. It is important to provide enough information in the description so that you can identify the subject six months later. For example, if the subject is wearing a hat, have them remove the hat so that you can see their full hairstyle/color. Additionally, identify whether they have any piercing, tattoos, or other body modifications. Describe their general body type.

Grooming: Describe their current clothing. Identify whether it is clean or in disrepair. Identify whether their clothing is appropriate for the climate and setting. How is the subject's hygiene (well kempt, evidences neglect, acceptable, body odor, etc.)?

Eye Contact/Presentation: Identify the quality of their eye contact, as well as their general demeanor during the assessment. That is, are they open, responsive, defensive, guarded, resistant, rebellious, or hostile? Circle the most appropriate descriptive and add any other useful descriptors to the line.

Speech: Identify any eccentricities with regard to rate, rhythm, or volume of their speech. Identify if there are any restrictions or unique qualities to their vocabulary.

Attitude: Circle the appropriate descriptor or add a descriptor reflecting how the subject engaged in the assessment process.

Orientation: Ask the following questions: "What is your name?" "What is my name?" "Where are you currently?" "What city are you in?" "What is today's full date?" "What is today's day of the week?" "What time is it?"

Recent Recall: "Name five things you saw in the waiting room."

General Fund of Knowledge: "What is the name of the current U.S. President?" "What is the name of the previous U.S. President?" "Who was the first President of the United States?" "Who was the President of the United States during the Civil War?"

Abstract Reasoning: "In what way is an apple and a banana the same? What category do they both belong to?" "In what way is a coat and suit the same? What category do they both belong to?" "In what way is a poem and statue the same?"

Estimate of IQ: Simply provide your best estimate of the intellectual range in which the person is currently functioning; this should be based on their general presentation as well as the preceding questions.

Affect(External): Circle the most appropriate affective descriptor or add other affective descriptors to the list.

Mood (Internal): Identify their prevailing mood by circling the appropriate descriptor or adding other descriptors at the end of the line.

Anxiety: Identify any indicators of pathological anxiety by circling the appropriate item on the list, or adding items to the end of the list.

Bizarre Ideation: Are they currently identifying any bizarre or unusual thoughts or mannerisms?

Suicidal/Homicidal: Are they currently evidencing any suicidal or homicidal ideation?

Current Stressors: "What is the thing that you are most stressed out about currently?"

Coping Mechanisms: "What are you doing to cope with this stress?"

Other Acute Risk Factors: Identify any other significant dynamics that may be impacting the subject's current functional status.