CLINTON COUNSELING CENTER
STUDENT SOCIAL MEDICAL QUESTIONNAIRE

Please respond to ALL questions/information. There are multiple two sided pages. Check to be sure you have completed them all. Provide the requested information to the best of your ability.

Identifying Data:

Name: ____ Birth Date:____/____/____ Age:_______ Sex________

Address: ____
(Street) (City) (State) (Zip Code)

Phone Numbers: Home: (_____)-______-______ Emergency Contact: Name _______________ #(_____)-_____-______

Why are you coming in for counseling at this time: ____

____

How long has this situation been a problem or concern for you? ____

How did you hear about Clinton Counseling Center? ____

Have you ever been to Clinton Counseling Center before for any reason? [ ] Yes [ ] No [ ] Unsure

If so, when? ____ _______

Race: [ ] Caucasian [ ] Black [ ] Hispanic [ ] Asian [ ] Native American [ ] Other: ______________________

Is there **ANY CHANCE** that you are currently pregnant? [ ] Yes [ ] No [ ] Unsure [ ] N/A

Family/Cultural Information:

Who is raising you? ______________________ # in your family:_______ # of Brothers: _____ # of Sisters:_______

Parents Current Marital Status: __________________ If parent (s) deceased, how old were you at the time? __________

If parents divorced, how old were you at the time: ______ Who raised you after the divorce? _______________________

Who do you live with? ____

Describe your relationship with:

Your father: ____

____

Your mother:____ _________________________________

____

Your brothers and sisters: ____

____

Can you talk to your mom, dad, brothers, or sisters about your problems or concerns? [ ] Yes [ ] No

If no, who do you talk to when you have a problem? ____

Are there consequences set by your parents when you misbehave or disobey house rules? [ ] Yes [ ] No

How do you feel about this? ____

Educational History:

Highest level of achievement:[ ] Still in school: What grade are you in: _______ What school do you go to? ___________

[ ] High School Graduate [ ] GED Completion [ ] Some College (Credits: ________)

[ ] Dropped out of school - Reason: _______________________________ What was highest grade completed? ________

School performance: [ ] A-B Student [ ] B-C Student [ ] C-D Student [ ] Failing

Have you ever been suspended from school? [ ] Yes [ ] No

Have you ever been expelled from school? [ ] Yes [ ] No

Have you ever repeated a grade? [ ] Yes [ ] No

Have you ever been enrolled in special education classes? [ ] Yes [ ] No

Do you have trouble concentrating, understanding, or remembering? [ ] Yes [ ] No

Do you like school? [ ] Yes [ ] No

If "No," Why not? ____

What would make school better for you? ____

Religious/Spiritual Background:

Do you practice your religion? [ ] Regularly [ ] Irregularly [ ] Never

What is you current religious preference/affiliation: ____

Do you believe in God/Higher Power? [ ] Yes [ ] No

Vocational Background:

Are you currently employed? [ ] Yes [ ] No If employed, length of employment at present job: ____________

If employed, how many hours a week do you work? ____

Job Title/Position: _______________________ Are satisfied with your work? ___________________________________

Job History: Type Work | Length of employment | Reason for leaving | Degree of Satisfaction

_________________________ _________________ ______________ ________________________

_________________________ _________________ ______________ ________________________

If you experience any problems with employment state them: ____

Sexual Background:

Are you sexually active? [ ] Yes [ ] No [ ] Unsure

If so, what type of birth control have you been using? ____

I consider myself to be: [ ] Heterosexual [ ] Homosexual [ ] Bisexual [ ] I am uncertain about my sexuality

Have you ever been: [ ] Sexually Abused [ ] Physically Abused [ ] Emotionally Abused

By whom? ____

Age when abused: _______________ Duration of Abuse: ___________________

Did you receive any kind of help after being abused? ____

If so, what kind and by whom? ____

Social Background:

With whom do you spend <u>MOST</u> of your free time: [ ] Family [ ] Friends [ ] Acquaintances [ ] Alone

How often do you see your friends/acquaintances: [ ] Daily [ ] Frequently [ ] Occasionally [ ] Rarely [ ] Never

Do you have a best friend outside of your family? __________ How often do you see that person? __________________

How many close friends do you have?___________ How many acquaintances do you have? _________________

What do you and your friends/acquaintances typically do together?____

Does your mom/dad/care giver like your friends? ____

Have you recently changed your circle of friends/best friend? [ ] Yes [ ] No

If so, what were the circumstances? ____

Do you ever feel as if you do not belong? [ ] Yes [ ] No

Do you have trouble making or keeping friends? [ ] Yes [ ] No

Do you have a curfew? [ ] Yes [ ] No Have you had problems following house rules? [ ] Yes [ ] No

Do you have chores? [ ] Yes [ ] No If so, what chores are you responsible for? ____________________________

Have you ever run away from home? [ ] Yes [ ] No

Is there anything that you would like to see change at home that would make your life better? [ ] Yes [ ] No

If so, what things would you like to see change? ____

Leisure Time/Interests:

List any hobbies, interests, or school activities: ____

Do you participate in your hobbies etc? [ ] Regularly [ ] Sometimes [ ] Irregularly [ ] Rarely [ ] Never

Has your use of leisure time changed in the past year? [ ] Yes [ ] No

If yes to above question, describe changes: ____
____

Describe your typical day: ____
____

Legal Status:

I am currently:[ ] On probation [ ] Awaiting charges [ ] Awaiting trial/Sentence [ ] No police involvement

How many times have you been arrested or ticketed in the **last 5 years**? __________ In the **last 6 months**? __________

Charges	Date	Outcome	Alcohol/Drug Related	
____________________________	_________	_______________________	[ ] Yes	[ ] No
____________________________	_________	_______________________	[ ] Yes	[ ] No
____________________________	_________	_______________________	[ ] Yes	[ ] No

Have you ever been in the Youth Home before? [ ] Yes [ ] No

Medical/Health History:

Do you have a routine health care provider (non-emergency room)? [ ] Yes [ ] No

If so, please provide the doctor/practice name and city where the office is located:

____

Have you had a physical exam in the last year? [ ] Yes [ ] No

Do you have any current medical complaints or recurring physical symptoms/pain that you are not receiving medical attention for? [ ] Yes [ ] No

Do you have any current physical impairments or disabilities that you are not receiving medical attention for? [ ] Yes [ ] No

Do you have health insurance? [ ] Yes [ ] No

Have you ever talked with a therapist or counselor before? [ ] Yes [ ] No

If so - for what reason(s):

Problems	Year/Age	Outcome

Do you presently feel suicidal: [ ] Yes [ ] No Do you presently feel homicidal: [ ] Yes [ ] No

Have you ever attempted to or had serious thoughts of suicide or of hurting other people? [ ] Yes [ ] No

If so, when did this happen and what was the outcome? ____

____

Any current medications that you take for any reason:

Type/Name/Dosage	Why do you take it?	Who prescribes this for you?

For the last month have you been: [ ] Sleeping too much [ ] Not sleeping enough [ ] Getting the right amount of sleep

Do you currently experience: [ ] Trouble getting to sleep [ ] Frequent waking [ ] Early rising [ ] None of these problems

Have your sleeping habits changed in the last 6 months? [ ] Yes [ ] No

If so, how? ____

For the last month have you been: [ ] Under eating [ ] Starving myself [ ] Over eating [ ] Eating with no trouble

You eat: [ ] A well balanced diet [ ] Junk food [ ] Fast foods [ ] Whatever is available, without thought

Have your eating habits changed in the last 6 months? [ ] Yes [ ] No

If so, how? ____

Alcohol/Drug Use:

Have you used **ANY** alcohol or drugs **in the last 30 days** that were not prescribed for you? [ ] Yes [ ] No

Have you used any drugs by injection in the **last 10 years**? [ ] Yes [ ] No

If so, when was the last time and which drug(s) were you injecting? ________________________________

Do you smoke cigarettes? [ ] Yes [ ] No

When was the last time you used **ANY** drugs or alcohol? ____

Do you live with any people who use alcohol or other drugs? [ ] Yes [ ] No

If so, what concerns (if any) do you have about this? ____

Do you live in an environment/neighborhood where alcohol or other drugs are easily available to you? [ ] Yes [ ] No

If so, what concerns (if any) do you have about this? ____

What kinds of problems (if any) has alcohol or other drug use caused in your life to date? ____________________

____

Please place a check **mark in the box** of any substance you have **used in the last 12 months**. Please mark the number of days you have used each drug **in the last 30 days in the space following** each drug:

Used?	# of days in last 30	Used?	# of days in last 30	Used?	# of days in last 30
[ ] Alcohol	________	[ ] Opiates/Heroin	________	[ ] Cocaine	_________
[ ] Crack	________	[ ] Sedatives	________	[ ] Barbiturates	_________
[ ] Amphetamines	________	[ ] Marijuana	________	[ ] Hallucinogens	_________
[ ] Steroids	________	[ ] Inhalants	________	[ ] Other	_________

What is your preferred substance? ____

Do you use substances while: [ ] Alone [ ] With others [ ] Both

Additional Information: Do you have anything to add to this information: ____________________________

____

____

____

_______________________________________ _______________________________
(Signature of Person Providing Information) (Date)

____
(Relationship to Patient)

I have reviewed this questionnaire with the patient/client:

_______________________________________ _______________________________
(Therapist Signature and Credentials) (Date)

Revision: 11/99 SLM