Adult Clinic

Social History

Date ____________________

Name Birthdate

☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed

Employer

Spouse's Employer

Source of income if not employed

Do you have ☐ Health Insurance ☐ Medicaid ☐ Medicare?

Emergency Contact: Name: Relationship Phone

People you live with:

Name	Relationship	Age
1.		
2.		
3.		
4.		
5.		

Last grade of school ___________ GED or Diploma? Yes No

Do you plan to obtain any type of higher education? ______ If so, what type?

Do you have any problems with:

Housing ☐ Yes ☐ No

Food ☐ Yes ☐ No

Transportation ☐ Yes ☐ No

Employment ☐ Yes ☐ No

Other ☐ Yes ☐ No

Do you have any problems now that are worrying you? ________________________________

Health Matters

1. Have you ever been pregnant?	☐ Yes	☐ No
2. Do you have any children?	☐ Yes	☐ No
3. Do you smoke cigarettes?	☐ Yes	☐ No
4. Do you use Drugs?	☐ Yes	☐ No
5. Do you drink beer, wine, or other alcohol?	☐ Yes	☐ No
6. Do you have a problem with depression?	☐ Yes	☐ No
7. Have you ever tried to commit suicide?	☐ Yes	☐ No
8. Have you ever had a sexually transmitted disease (STD)?	☐ Yes	☐ No
9. Have you had a ☐ Miscarriage ☐ Abortion?	☐ Yes	☐ No
10. Have you ever been the victim of ☐ Physical Abuse ☐ Sexual Abuse		☐ No

PLEASE STOP HERE

Significant Social History: ____

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Referral/Plans: ____

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