# *Psychosocial History*

Name: _____

Age: _____

Self-Identified Race: _____

Cultural Background: _____

Are they coming for:

| | |
|---|---|
| ☐ | Comprehensive treatment – to resolve issues |
| ☐ | Symptom reduction – short term treatment to just decrease a symptom |

Overview of what they would like to address.

| |
|---|
| |

Symptoms reported:

| | |
|---|---|
| Symptom: | |
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| Symptom: | |

From the overview of what your client wishes to address, the symptoms above, and the history below, create ***Presenting Issues*** to put on the ***Master Treatment Plan*** for Reprocessing.

A ***Presenting Issue*** is a:

1. Present Anxiety (or affective state that is problematic)
2. Belief System
3. Pattern of Response or Behavior
4. Body Sensation/Symptom (headaches, stomach aches, irritable bowel)

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Client's History:

Have they been in therapy before? ☐ Yes ☐ No
If so, give a brief description of how many times, what for and what were the results?

Give a brief description of your client's developmental history. Experience while in utero, amount of time on belly in infancy creeping, crawling, cross patterning, sitting, standing, etc. *This information will give you some indication if there has been incomplete neurological development contributing to learning disabilities, and other diagnosis.* Have your client ask family if they are unaware.

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Give a brief description of their attachment history:

Have they experienced physical abuse? ☐ Yes ☐ No
If yes please give a brief description of when, how often, by who:

Have they experienced sexual abuse? ☐ Yes ☐ No
If yes please give a brief description of when, how often, by who:

Have they experienced emotional abuse? ☐ Yes ☐ No
If yes please give a brief description of when, how often, by who:

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Are there major losses in their life? ☐ Yes ☐ No
Please describe:

Were they ever removed from their home as a child? ☐ Yes ☐ No
Please describe:

Are there other big T traumas? ☐ Yes ☐ No
Please describe:

Are there other small t traumas? ☐ Yes ☐ No
Please describe:

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How are they sleeping?

How is their diet?

Do they have: *Check all that apply.*

- ☐ Depersonalization and/or Derealization
- ☐ History of hospitalizations
- ☐ Somatic symptoms
- ☐ Chronic instability at home and/or at work
- ☐ Inability to learn from experience
- ☐ Previous unsuccessful treatment of addictions and/or compulsions
- ☐ Secondary gains to maintaining their symptomatology
- ☐ Dissociative Disorder

Have you done the DES? ☐ Yes ☐ No

## *Medications*

Is your client currently on any medications? ☐ Yes ☐ No

If yes, what are they taking? What dosage? How often? Prescribed by who?

| Medication/For What | # per day | #per week | # per month | # per year |
|---|---|---|---|---|
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Do they use *Medical* Marijuana? ☐ Yes ☐ No

How much? How Often?

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Do they have minimal or poor responses to psychotropic medications?
☐ Yes ☐ No

## *Recreational Drugs*

Do you drink alcohol? ☐ Yes ☐ No
If yes, how many drinks do they have a /Day /Week /Month /Yr

What type and size of drink do they drink?

Do they use non-prescription drug or street drugs (marijuana, Cocaine, LSD, crank, crack, amphetamines, etc.)? ☐ Yes ☐ No
If yes, please list what you use and how often:

| Drug | How much? | How often? |
|---|---|---|
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Do they have a history of unsuccessful addiction treatments? ☐ Yes ☐ No
If yes, how many times?:

## *Medical History*

What is your client's general physical health/medical condition?

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Debra A. Littrell
Transformative Spirit, LLC

Have they ever been hospitalized for mental or emotional issues? ☐ Yes ☐ No
If yes, when, what for, for how long and where?

Is inpatient necessary to manage danger to self or others?

Have they had any surgeries? ☐ Yes ☐ No
If yes, what for and when?

Have they had any serious illnesses? ☐ Yes ☐ No
If yes, what illnesses and when?

Do they currently have medical problems, any disabilities (emotional, physical or learning), or illnesses? ☐ Yes ☐ No
If yes, please describe.

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Are they pregnant? ☐ Yes ☐ No
If so, are there any first trimester cautions or other complications?

## *Stabilization*

What skills/tools does your client have to managing distress during and between sessions?

What result do they get when they use them on their own?

What systems/issues might endanger your client, and have they been addressed?

Marital Status

| | |
|---|---|
| ☐ | Single |
| ☐ | Married For how many years: |
| ☐ | Divorced For how many years: |
| ☐ | In a life-long commitment For how many years: |
| ☐ | Alternative Relationship(s) For how many years: |

What social support system do they have?

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Do they have any spiritual/religious beliefs that play an important role in their life?

Have there been any spiritual or religious wounding?

Is your client safe at home? ☐ Yes ☐ No If not how so?

Is your client able to call for help if needed?

What internal resources does your client have?

What external resources does your client have?

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What are their strengths?

What positive experiences do they have available in their life? (adaptive memory networks).

## *Acute Issues*

Is their currently life-threatening substance abuse? ☐ Yes ☐ No Describe:

Have there been recent suicide attempt(s)? ☐ Yes ☐ No Describe:

Are they Self-mutilating? ☐ Yes ☐ No Describe:

Is there serious assaultive or impulsive behavior? ☐ Yes ☐ No Describe:

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Has there been any recent psychotic episodes? ☐ Yes ☐ No Describe:

## *Further considerations before beginning Reprocessing Phases 4-6*

Do they have Eye pain? ☐ Yes ☐ No
If so, have they been cleared by a physician before using eye movements?

Are there any neurological impairment or physical complication inappropriate for Weekend 1/Part 1 clinicians? ☐ Yes ☐ No
If so, have you spoken with their physician to assess appropriateness of reprocessing phases? If so, what are their recommendations?

Are there any legal proceedings? ☐ Yes ☐ No
If so, have you educated and gotten permission from their representing attorney to proceed? What are their recommendations?

Do they have timing of life events (projects, demands, work schedules, vacations, etc.) that could disrupt being consistent for reprocessing sessions? ☐ Yes ☐ No
If yes, what plan have you and your client come up with to address these issues?

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Do you have your client scheduled weekly to start reprocessing sessions?

☐ Yes ☐ No

☐ 90 minute sessions ☐ 50 minute sessions

Is your client willingness/able to participate in the treatment plan? ☐ Yes ☐ No

Is your client able to integrate new information? ☐ Yes ☐ No

Does your client have good affect tolerance for both positive and negative experiences?

☐ Yes ☐ No

If no, what is your plan to prepare them?

Are they ready and motivated for change? ☐ Yes ☐ No

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