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Psychosocial Assessment

Name: _____ Date: _____

Age: _____ Sex: _____ Therapist: _____

Directions: Please answer the following questions as fully as possible.

Present Problem-Precipitating Stressors "In the recent months, I have worried a lot about: (Please circle all that apply)

Marital issues Health issues Job issues Financial issues

Parent/child issues Issues of past (guilt, abuse, neglect, family of origin etc.)

Other _____

Symptoms (Please circle all that apply)

Change in sleep pattern Decreased concentration Change in appetite

Increased anxiety Decreased energy Suicidal feelings

Decreased motivation Other _____

Suicidal/Homicidal Ideation

Have you ever attempted to commit suicide or homicide in the past? _____

If yes, how? _____

Is there a history of suicide in your nuclear and/or extended family? _____

Have you ever inflicted burns or wounds to yourself? _____

Are you presently suicidal/homicidal? _____

Recent Losses (Please circle all that apply)

Family Health Disruption in lifestyle Job Significant other

Other _____

Psychiatric History

Please list any previous outpatient counseling experiences.

Place _____Reason_____

Length of time _____ Dates _____

Place _____Reason_____

Length of time _____ Dates _____

Have you ever been admitted to the hospital for mental health or addiction issues? ____

Place _____ Reason _____

Length of time _____ Dates _____

Name of current psychiatrist _____

List all medications you have taken in the past for anxiety, depression, and/or sleep

Medical Information

Describe any current medical condition _____

Are you currently on any medication _____ Please list the name of the medication,

the dosage, the frequency and the prescribing physician _____

Are you currently taking any herbs, if yes please list them_____

Has it been more than a year since your last physical exam including blood test? _____

Have you ever had an abortion? _____

Do you have any allergies? _____

Please list any previous health problems, operative procedures, and medical hospitalization _____

Substance Abuse History

Describe your current usage, or usage within the past year of alcohol, caffeine, tobacco, pornography, gambling, and prescription pain medication (Please list the substance, the amount, the frequency, the age of 1st use, the age regular use started, and the date of last use). _____

Have you experienced a recent increase in the use of alcohol and/or other substances? _____

Do you see your current usage as a problem? _____

Please describe any previous experience with drugs or alcohol _____

Describe any significant family history of substance abuse_____

Nutrition

Have your eating habits changed recently? Yes No If yes, please describe_____

Has your weight fluctuated more than +/- 10lbs. over the previous year? Yes No

Do you often eat out of depression, boredom, and anger? Yes No If yes, please describe_____

Do you ever self-induce vomiting? Yes No

How do you feel about eating with others in a group? _____

Do you ever binge eat or feel your eating is out of control? Yes No If yes, please describe_____

If you use laxatives, water pills, or diet medications, how often do you use them? _____

Legal History (Please explain all that apply)

Charges as a minor_____

Charges presently_____

Arrests (How many) _____

Incarcerations (How many) _____

Parole _____

Convictions (How many) _____

Probation _____

Bankruptcy _____

Civil suits _____

Child custody problems _____

Developmental History

List members of your family that you grew up with and how you got along with each one.

What was your birth order? ____of ____ children Who primarily raised you? _____

How would you describe your childhood? Traumatic Painful Uneventful

What were you like as a child (include friends, school, hobbies, and personality)? _____

_____

Were there any unusual or traumatic experiences for you as a child? (Please list the age that it occurred and the event that occurred)

What is your sexual orientation? Heterosexual Homosexual Bisexual

Support System

Who can you count on for support?

Parents Spouse Siblings Employer ChurchPastor

Therapist Neighbor Extended Family Close Friend

Self-help Group Community Services Co-Worker Medical Dr.

Who are you currently living with? _____

Financial Situation

Describe briefly your financial situation _____

Marital History (if applicable)

What was the date of your current marriage? _____ Name and age of spouse

_____

Previous marriage? Yes No If yes, date of divorce _____

Any children from this marriage? _____

What is your perception of your current marriage (include communication patterns,

problems, sexual relations) _____

_____

Please list that name, ages and the custodial parent of each of your children. How do

you get along with each one? _____

Religious/Cultural Factors

Please list any issues that are important or may have affected you in regard to religion or

ethnic/cultural background. _____

What is your religious background? _____

Do you currently attend church, synagogue or mosque? Yes No If yes, please

list where you attend. _____

Work History

Describe your current job/career _____

Would you enjoy doing this job on a long-term basis? _____

If you could have any job/career, what would you choose? _____

Why would you choose this? _____

How do you deal with authority figures? _____

Describe your relationship with co-workers _____

Describe your job performance _____

Have you ever been fired? Yes No If yes, explain _____

How many jobs have you held within the previous five years? _____

Were you ever in the military? _____

Educational History

Highest level achieved _____ What type of grades did you make? _____

Are you currently in school? Yes No If yes, what level? _____

Family

Would it be beneficial for any members of your family to be involved in your treatment?

Yes No If yes, explain _____

Is there anything else you feel that we need to know about you? Yes No If yes,

please explain _____

SIGNATURE OF CLIENT_____ DATE_____

PARENT SIGNATURE IF UNDER 16_____