# PSYCHOSOCIAL ASSESSMENT

Name: _____ Age: _____ Sex: _____

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

What event(s) have prompted you to seek counseling?

_____

_____

_____

When did these problems develop? _____

_____

**Problem Assessment:**

Present Problem/Stressors: *Please circle all that apply:*

Marital/Relational Health Issues Grief/Loss Job/Career Financial
Parent/Child Past Issues (abuse, neglect, childhood/family of origin issues)
Other _____

Symptoms: *Please circle all that apply:*

| | | |
|---|---|---|
| Sleep Problems | Depressed Mood | Mood Swings |
| Energy Loss/Fatigue | Shy/Lonely | Alcohol/Drug Issues |
| Decreased Concentration | Worry/Obsessing | Sexual Concerns |
| Decreased Motivation | Fear/Panic | Disturbing Thoughts |
| Appetite Changes | Anger Problems | Thoughts of Death |

Other _____

Suicidal/Homicidal Ideation:

Have you attempted to commit suicide or homicide in the past? □ yes □ no
Is there a history of suicide in your nuclear and/or extended family? □ yes □ no
Have you ever inflicted burns or wounds to yourself? □ yes □ no
Are you presently suicidal/homicidal? □ yes □ no
Any other risk taking behaviors that you engage in? □ yes □ no

**Psychiatric History:**

Have you ever had any previous outpatient counseling? □ yes □ no
If yes, list dates, length of time and reason: _____
Was it helpful? □ yes □ no How so? _____
Have you ever been admitted to the hospital for mental health or addiction issues? □ yes □ no
If yes, list dates, places and reason: _____
Was it helpful? □ yes □ no How so? _____
List all current medications you are taking for anxiety, depression, sleep, etc: _____

_____

List all medications you have taken *in the past* for anxiety, depression, sleep, etc: _____

_____

**Medical Information:**

How would you describe your current condition of health? _____
Do you have any disabilities and/or health problems? □ yes □ no
If yes, explain: _____

**Substance Use History:**
Describe your current and past usage of the following substances:

| Substance | Amount | Frequency | Age 1st Use | Age Regular Use Started | Last Use |
|---|---|---|---|---|---|
| tobacco | | | | | |
| alcohol | | | | | |
| marijuana | | | | | |
| cocaine | | | | | |
| stimulant | | | | | |
| opiates | | | | | |
| other | | | | | |

Have you experienced a recent increase in the use of alcohol and/or other substances? □ yes □ no
Do you, your family, or your friends see your current usage as a problem? □ yes □ no
Describe any significant family history of substance abuse: _____
_____

**Nutrition:**
Do you feel you have balanced, healthy eating patterns? □ yes □ no
Do you have a lot of concerns about your weight and shape? □ yes □ no
Do you often eat out of depression, boredom, anger? □ yes □ no
Do you ever binge eat or fear losing control of your eating? □ yes □ no
Do you ever self-induce vomiting? □ yes □ no
Do you use laxatives, water pills, or diet medications to control your weight? □ yes □ no
Do you or others believe you exercise excessively? □ yes □ no

**Educational History:**
What was school like for you? _____
Highest Level Achieved: _____ What type of grades did you make? _____
ADHD? □ yes □ no Learning Disabilities? □ yes □ no
Currently in school? □ yes □ no If yes, what level? _____

**Work History:**
Current Job/Career: _____
What do you enjoy about this job/career? _____
What do you dislike about this job/career? _____
Describe your relationship with authority figures? _____
Describe your relationship with co-workers? _____
Describe your job performance: _____
Have you ever been fired or laid-off? □ yes □ no If yes, explain: _____
_____
How many jobs have you had in the last five years? _____

**Military History:**
List branch, dates, and duties:
_____
_____

**Financial Situation:**
Describe briefly your financial situation: _____
_____

**Developmental History:**

How would you describe your childhood? □ Traumatic □ Painful □ Uneventful □ Good /Happy

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

_____

_____

_____

List members of your childhood family and comment on how you got along with each one:

| Name | Relationship | Comment |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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

Were there any unusual or traumatic experiences for you as a child?

| Date | Age | Event |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Have you ever been the recipient of unwanted sexual acts? □ yes □ no

If yes, please explain: _____

Have you ever been the victim of abuse, neglect, or violence? □ yes □ no

If yes, please explain: _____

Have you ever been the perpetrator of abuse towards another person? □ yes □ no

If yes, please explain: _____

Have you ever had an abortion? □ yes □ no

What is your sexual orientation? □ Heterosexual □ Homosexual □ Bisexual

**Marital History (if applicable):**

When were you married? _____ Name and age of spouse: _____

What is your perception of your current marriage (strengths, weaknesses, communication, etc.)?

_____

_____

_____

_____

Previous marriages(s): □ yes □ no Name and Dates: _____

List names and ages of children and how you get along with each:

| Name | Age | Comment |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Religious/Cultural Factors:**

What is your religious background? _____

_____

Do you currently attend church, synagogue, or mosque? □ yes □ no

What does God seem like to you? _____

Describe your relationship with God? _____

_____

What do you consider to be the role of God in your recovery? _____

_____

**Social Relationships/Support System:**

What are your hobbies or leisure activities? _____

_____

Do you have any close friends? ☐ yes ☐ no If yes, describe: _____

_____

Who do you rely on for support? _____

_____

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

☐ yes ☐ no

If yes, explain who and how/why: _____

_____

What is your family's perception of your difficulties? _____

_____

_____

**Miscellaneous:**

Are there any other things that can be helpful for us to know about you? _____

_____

_____

_____

List your strengths and weaknesses:

| Strengths | Weaknesses |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

What would you like to accomplish during your treatment? _____

_____

_____

Signature: _____ Date: _____

Clinician: _____ _____ Date: _____