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PSYCHOSOCIAL ASSESSMENT

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Race: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Number: \_\_\_\_\_

Presenting Problem: \_\_\_\_\_

Prior Treatment History (include type of program and duration): \_\_\_\_\_

PHYSICAL HEALTH mSTORY

General Health:      Excellent      Good      Fair      Poor

Sleep Problems:      None      Occasional      \_ Frequent

Describe: \_\_\_\_\_ Hours per night: \_\_\_\_\_

Appetite:      Excellent      Good      Poor

Recent gain or loss of weight?

Check all that apply:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Severe Headaches           | <input type="checkbox"/> Nausea/Nomiting     | <input type="checkbox"/> Nose Bleeds     |
| <input type="checkbox"/> High/Low Blood Pressure    | <input type="checkbox"/> Numbness/tingling   | <input type="checkbox"/> Severe Injury   |
| <input type="checkbox"/> Shortness of Breath        | <input type="checkbox"/> Vision Problems     | <input type="checkbox"/> Back Injury     |
| <input type="checkbox"/> Asthma/ Chronic Cough      | <input type="checkbox"/> Heart Pounding      | <input type="checkbox"/> Hearing Trouble |
| <input type="checkbox"/> Difficulty Concentrating   | <input type="checkbox"/> Dizziness/Fainting  | <input type="checkbox"/> Loss of Memory  |
| <input type="checkbox"/> Abdominal Pain/Indigestion | <input type="checkbox"/> Chest Pain/Pressure |  |

If checked, specify current condition: \_\_\_\_\_

- Personal or family history of:
- |  |                                 |                                   |   |
|--|---------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid problems |
|  | <input type="checkbox"/> TB     | <input type="checkbox"/> Other    |   |

Major Surgeries or Injuries / year:

Primary Physician: \_\_\_\_\_ Last Seen: \_\_\_\_\_

Do you have any special needs due to age, sex, health, other? If yes, explain: \_\_\_\_\_

EDUCATIONAL HISTORY

Highest Grade Completed: \_\_\_\_\_ GED: \_\_\_\_\_ College: \_\_\_\_\_

Additional Education/Training: \_\_\_\_\_

Any difficulties reading or writing? \_\_\_\_\_

Describe school years: \_\_\_\_\_

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**WORK HISTORY**

**Current employer:** \_\_\_\_\_

**Type of work and work environment:** \_\_\_\_\_

**Previous Employer:** \_\_\_\_\_

**Type of work and work environment:** \_\_\_\_\_

\_\_\_\_\_ **Reason for leaving:** \_\_\_\_\_

**Is your current employer supportive of treatment?** \_\_\_\_\_

**FAMILY HISTORY**

**Describe your current living environment.**

**Current partners name & age:** \_\_\_\_\_

**List marriages and relationships:**

**Name ( Age:** \_\_\_\_\_ **Reason for leaving:** \_\_\_\_\_

**Name ( Age:** \_\_\_\_\_ **Reason for leaving:** \_\_\_\_\_

**Name ( Age:** \_\_\_\_\_ **Reason for leaving:** \_\_\_\_\_

**List children (living or deceased:**

**Name ( Age:** \_\_\_\_\_ **Current relationship:** \_\_\_\_\_

**Name ( Age:** \_\_\_\_\_ **Current relationship:** \_\_\_\_\_

**Name ( Age:** \_\_\_\_\_ **Current relationship:** \_\_\_\_\_

**Name ( Age:** \_\_\_\_\_ **Current relationship:** ~ \_\_\_\_\_

FAMILY OF ORIGIN:

Mother: \_\_\_\_\_ Drug usage? \_\_\_\_\_

Father: \_\_\_\_\_ Drug usage? \_\_\_\_\_

Step Mother or Father? \_\_\_\_\_ Drug usage? \_\_\_\_\_

Comments: \_\_\_\_\_

Brothers and sisters: (Names, Ages, Current Relationship, and Drug Usage:

How is your support system? (People you confide in): \_\_\_\_\_

Describe what it was like growing up in your family: \_\_\_\_\_

Identify any alcoholism / chemical dependency in your family: \_\_\_\_\_

Any mental illness?: \_\_\_\_\_

Identify any past or current physical abuse in your life: \_\_\_\_\_

MILITARY mSTORY

Describe military history and experience: \_\_\_\_\_

FINANCIAL ASSESSMENT

Describe current income sources and any financial problems: \_\_\_\_\_

SOCIAL / LEISURE ASSESSENT

Describe current social activities, hobbies, and friends: \_\_\_\_\_

CULTURAL / SPIRITUAL HISTORY

Describe your cultural background: \_\_\_\_\_

Describe your religious background: \_\_\_\_\_

Current religious practices: \_\_\_\_\_

PSYCHOLOGICAL HISTORY

Describe previous treatments for emotional problems:

Agency Name

Treatment Type

Outcome

Describe any past or current thoughts or attempts at suicide: \_\_\_\_\_

Describe any past or current psychological abuse or trauma: \_\_\_\_\_

SEXUAL HISTORY

Check sexual preference: Heterosexual \_ Homosexual                      Bisexual                      Asexual

Describe any sexual problems you are experiencing: \_\_\_\_\_

Describe any past or current sexual abuse or trauma: \_\_\_\_\_

CLIENTS PERCEPTION OF STRENGTHS AND ABILITIES

Strengths: \_\_\_\_\_

Abilities: \_\_\_\_\_

Areas for Improvement: \_\_\_\_\_

CHEMICAL USE HISTORY

DRUG CATEGORY Circle all that apply	Age of first use	Maximum Use	Current Use	Date of Last Use
Alcohol				
Marijuana, Hashish				
Cocaine, Crack				
Nicotine (Tobacco)				
Amphetamines, Speed Diet Pills, Crystal Meth				
Barbiturates, Sedatives Sleepin! Pills, Ativan				
Prescription Drugs Percoset, Zanax Valium, Librium Darvocet				
Opiates,                      Heroin, Dilaudid, Codeine Methadone				
Hallucinogenics LSD, Acid, Mushrooms				
Major Psychotropics Thorazine, Haldol Mellaril				
Designer Drugs Ecstasy, Ruffies				
OTHER:				

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Level of substance abuse impairment: Mild                      Moderate                      Extensive

Under what circumstances do you tend to drink/drug the most? \_\_\_\_\_

Symptoms

Use of drink more than intended: YES                      --                      N  
 Blackouts: YES                      --                      NO                      O

Excessive amount of time spent in drug related activities: YES \_\_\_\_\_ N  
 One or more attempts to stop: YES \_\_\_\_\_ NO \_\_\_\_\_ When: \_\_\_\_\_ O

Withdrawal symptoms: YES \_\_ NO \_\_

Continued use despite negative consequences YES \_\_ NO \_\_\_\_\_

Use of drug of choice to remove withdrawal symptoms YES \_\_ NO \_\_\_\_\_

Paranoia YES                      NO                      Panic Attacks  
 YES                      NO                      \_\_\_\_\_

Takes increased amounts to get drunk or high YES \_\_ NO \_\_

Problems due to drug use: Family \_\_ Work \_\_ Financial \_ Social \_\_

Attendance to AA/NA/CA/COA?      Yes \_\_\_\_\_ No \_\_\_\_\_ Please clarify time and  
 frequency: \_\_\_\_\_

Longest time period remaining drug and alcohol free: \_\_\_\_\_

Any legal charges or court appearances pending? If yes, explain: \_\_\_\_\_

Legal History ( Charge! Date! Outcome): \_\_\_\_\_

Do you require notifications! reports sent to court representative, Department of  
 Children and Families representative, mental health counselor, doctor, attorney or  
 employer?  
 If yes, explain: \_\_\_\_\_

Title and address of representative: \_\_\_\_\_

Below C'  
OFFICE USE ONLY

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MENTAL STATUS

MOOD

Normal \_\_ Paranoid Angry \_\_ Sad Nervous  
Self Depreciating \_\_ Manic Suicidal Homicidal

AFFECT

Normal/Congruent \_\_ Flat/Blunted \_\_ Inappropriate \_\_

ATTITUDE

Cooperative Withdrawn \_\_ Evasive \_\_ Manipulative Resistant  
Hostile

APPEARANCE

Appropriate / Clean Inappropriate for age / sex

ORIENTATION

Good contact with reality Difficulty with contact with reality \_\_  
Out of contact with reality

MEMORY

Immediate: Normal Impaired Uncertain  
Recent: Normal Impaired Uncertain  
Remote: Normal Impaired Uncertain

THOUGHT PROCESS

Spontaneous \_\_ Slow Possible Rapid \_\_ Dlogical \_\_  
thought disorder \_\_

THOUGHT CONTENT

Logical/Coherent \_\_ Confused \_\_ Delusional/Bizarre \_\_ Paranoid/Persecutory  
\_\_ Aggressive/Hostile \_\_ Retarded \_\_ Hallucinations: Auditory \_\_ Visual \_\_  
Tactile

JUDGMENT

Mature Immature \_\_ Impatient \_\_  
Self Image Good \_\_ Fair \_\_ Poor \_\_

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Clinical Impression: \_\_\_\_\_

Provisional Diagnosis: \_\_\_\_\_

AXIS I:

AXIS I:

AXIS II:

AXIS III:

AXIS IV: \_\_\_\_\_

AXIS V:

**Plan of action:**

THERAPIST:

DATE:

CLIENT NAME:

DOB: