



# PSYCHOSOCIAL ASSESSMENT

Age 16 and Above

Name: \_\_\_\_\_ Record# \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Clinician: \_\_\_\_\_

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

**Problem Assessment**

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

- Marital issues       Health issues       Job issues       Financial issues
- Parent/child issues     Issues of past (guilt, abuse, neglect, family of origin issues, etc.)
- Other \_\_\_\_\_

Symptoms: *Please check all that apply:*

- Change in sleep pattern       Depressed mood       Mood swings
- Decreased energy       Decreased interest or pleasure       Anger problems
- Decreased concentration       Change in appetite       Thoughts of death
- Decreased motivation       Anxiety/Worry/Panic
- Other \_\_\_\_\_

**Suicidal/Homicidal Ideation**

Have you attempted to commit suicide or homicide in the past?  yes  no

If yes, how? \_\_\_\_\_

Is there a history of suicide in your nuclear and/or extended family?  yes  no

Have you ever inflicted burns or wounds on yourself?  yes  no

Are you presently suicidal or homicidal?  yes  no

Are there any other risk-taking behaviors that you engage in?  yes  no

If yes, please explain \_\_\_\_\_

What event(s) in the recent past has prompted you to seek counseling? \_\_\_\_\_

\_\_\_\_\_

Describe additional problems you are experiencing. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did these problems develop? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Check any recent losses you have experienced.

- Family       Health       Disruption of lifestyle       Job       Significant other
- Other \_\_\_\_\_

List your strengths and weaknesses.

Strengths	Weaknesses

**Psychiatric History**

Have you ever had any previous outpatient counseling?  yes  no If yes, please complete information below.

Place	Length of Time	Date(s)

Have you ever been admitted to the hospital for mental health or addiction issues?  yes  no

Place: \_\_\_\_\_ Dates: \_\_\_\_\_

Name of current doctor and/or therapist: \_\_\_\_\_

Have you ever received a psychiatric diagnosis?  yes  no If yes, please explain. \_\_\_\_\_

Do you feel medications you have been on, past or present, have been effective?  yes  no

Please explain: \_\_\_\_\_

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

**Medical Information**

How would you describe your current condition of health? \_\_\_\_\_

Do you have any disabilities and/or disorders?  yes  no If yes, explain. \_\_\_\_\_

Explain any special adjustments needed for the disability or disorder: \_\_\_\_\_

Are you currently on any medication?  yes  no If yes, please complete the information below.

Name of Medication	Dosage/Frequency	Prescribing Physician

Are you allergic to any medications or have you ever had an adverse reaction to medication?  yes  no

If yes, please list: \_\_\_\_\_

Has it been more than a year since your last physical exam, including blood tests?  yes  no

Have you ever had an abortion?  yes  no Males: Has a child of yours ever been aborted?  yes  no

Do you have allergies?  yes  no If yes, explain. \_\_\_\_\_

List any previous health problems, operative procedures, and medical hospitalizations.

Problem	Dates	Treatment

**Substance Use History**

Describe your current usage, or usage within the past year (includes alcohol, any illegal drugs, caffeine and tobacco).

Substance	Amount	Frequency	Age of 1 <sup>st</sup> Use	Age regular use started	Last use

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 If yes, when did it become problematic? \_\_\_\_\_

Please describe any previous experience with drugs or alcohol. \_\_\_\_\_

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

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

Do you use laxatives, diuretics (water pills), or diet medications to control your weight?  yes  no

Do you or others believe you exercise excessively?  yes  no

**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 of origin and comment on how you got along with each one.

Name	Relationship	Comment

What was your birth order? I was the \_\_\_\_\_ of \_\_\_\_\_ children. Who primarily raised you? \_\_\_\_\_

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you have any unusual or traumatic experiences 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, neglect, or violence towards another person?  yes  no

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

What is your sexual orientation?  Heterosexual  Homosexual  Bisexual

**Living Arrangements**

Satisfactory?  Unsatisfactory?

Where do you currently live? \_\_\_\_\_ How long there? \_\_\_\_\_

With whom are you living? \_\_\_\_\_

Describe your current relationships with family members. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social Relationships/Support System**

Who can you count on for support? *Check as many as apply.*

- Parents  Spouse  Siblings  Extended Family  Employer  Church  Pastor  Co-worker
- Neighbor(s)  Close Friend  Self-help Group  Community Services  Therapist  Medical Doctor

List close friends, outside of family, if any. \_\_\_\_\_

What are your hobbies or leisure activities? \_\_\_\_\_

**Marital History (if applicable)**

When were you married? \_\_\_\_\_ Name and age of spouse. \_\_\_\_\_

Previous marriage(s)?  yes  no If yes, date of divorce(s). \_\_\_\_\_

How many children from above marriage(s)? \_\_\_\_\_

What is your perception of your current marriage (include communication patterns, problems, sexual relations).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List names and ages of children. How do you get along with each one?

Name	Age	Comment

**Financial Situation**

Describe briefly your financial situation. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Religious/Cultural Factors**

What is your religious background? \_\_\_\_\_

Describe the religious atmosphere in your home (past or present). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you currently attend church, synagogue, mosque, or other religious services?  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? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any issues (positive or negative) which are important or may have affected you in regard to religion or ethnic/cultural background. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Educational History**

What was school like for you? \_\_\_\_\_  
\_\_\_\_\_

Highest grade level achieved. \_\_\_\_\_ What type of grades did you make? \_\_\_\_\_  
Are you currently in school?  yes  no If yes, what grade level? \_\_\_\_\_

**Work Adjustment History**

Describe your current job/career. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

How do you deal 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 held within the previous five years? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Military History**

List branch, dates, and duties.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family**

Would it be beneficial for any member(s) of your family/legal guardian to be involved in your treatment?

yes  no If yes, explain who and why. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

May we contact any of the persons you have mentioned above for their input and involvement in your care?

yes Contact Information: \_\_\_\_\_

no

What is your family/legal guardian's perception of your difficulties? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Miscellaneous**

Are there any other things that would be helpful for us to know about you? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

With your permission, is there anyone else that would be appropriate to contact in regard to your care?

yes Name and phone number. \_\_\_\_\_

no

How were you referred to Meier Clinics®? \_\_\_\_\_

Is there anyone that we are legally required to notify in regard to your care?  yes  no

If yes, please give us the necessary information to contact them. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is there a need for assistive technology in your treatment?  yes  no If yes, what is that need? \_\_\_\_\_

What would you like to accomplish during your treatment with Meier Clinics®? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Read and Reviewed by \_\_\_\_\_

Date: \_\_\_\_\_

(Clinician)