



PSYCHOSOCIAL ASSESSMENT

Age 16 and Above

Name: _____ Acct. # _____

Age: _____ DOB: _____ 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 —*Please check all that apply:*

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

If applicable, please list abilities/interests and preferences that you have.

Abilities/Interests	Preferences

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. _____

Are you pregnant? yes no

Could you become pregnant? yes no

List any prenatal care you are receiving: _____

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

Problem	Dates	Treatment

Use History

Describe your current usage, or usage within the past year of the following items.

Substance	Amount	Frequency	Age of 1 st Use	Age regular use started	Last use
Caffeine					
Nicotine					
Marijuana					
Alcohol					
Other (please list)					

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, either experienced or witnessed?

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

What is your gender expression? Male Female Other _____

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? _____

How would you describe your current literacy 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?
explain who and why. _____

May we contact any of the persons you have mentioned above for their input and involvement in your care?
 yes no If yes, Contact Information: _____
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 no Name and phone number. _____
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)