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

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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:____

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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 1st 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. ____

____

____

____

____

____

____

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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. ______________________

____

____

____

____

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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? ____
____
____
____

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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®? __________________________

____

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____

____

____

____

Client Signature: ____ Date: _______________________

Read and Reviewed by ____ Date: _______________________

(Clinician)

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