MEIER CLINICS

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 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. _____

_____

_____

_____

_____

_____

_____

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)