

DEMOGRAPHICS - PSYCHOSOCIAL ASSESSMENT

DEMOGRAPHICS

Client's First Name: _____ Middle: _____ Last: _____

DOB: _____ County of Residence: _____

Street Address: _____

City: _____ State: _____ Zip: _____

*Providing contact information, telephone numbers, etc., indicates permission to be contacted.

Home Phone: _____ Cell Phone: _____

Contact Email Address: _____

Email Address to be sent Statements: _____

Marital Status: _____ Religious Affiliation: _____

EMERGENCY CONTACTS

Name: _____ Phone #: _____ Relationship to Client: _____

Name: _____ Phone #: _____ Relationship to Client: _____

RESIDENCE

Adequate Housing ☐ Inadequate Housing ☐ Notes: _____

of Times moved as a Child: _____ # of Times moved as an Adult: _____

EMPLOYMENT

Employer: _____ Full-Time ☐ Part-Time ☐ N/A ☐

EDUCATION

Student/School/College: _____ Full-Time ☐ Part-Time ☐ N/A ☐

Elementary ☐ Middle School ☐ High School ☐ College ☐ Number of years completed: _____

FINANCIAL STRESSORS

None ☐ Current financial stressors ☐ Large indebtedness ☐ Relationship conflict regarding finances ☐

Notes: _____

LEGAL HISTORY

No legal history ☐ Currently on Probation ☐ Discipline-ordered treatment ☐ Jail/Prison time served ☐

Arrest(s) non-substance related ☐ Arrest(s) substance related ☐

MILITARY

Active Duty ☐ / Branch: _____

SPIRITUAL

Do you believe in God or a "higher power?" _____

Religious Affiliation / History: _____

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SYMPTOMS and BEHAVIORS – PSYCHOSOCIAL ASSESSMENT

The following is a list of symptoms the client may or may not be experiencing. Choose “None” if the symptom has not been experienced. Choose “By History” the symptom has been experienced the past. Choose “Mild” if the symptom has impact but has no significant impairment of day-to-day functioning. Choose “Moderate” if the symptom has significant impact on day-to-day functioning. Choose “Severe” if the symptom has profound impact on day-to-day functioning.

	None	By History	Mild	Moderate	Severe	Duration	Notes
Aggressive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Appetite disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Behavior problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Binging/purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bowel/bladder disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Compulsive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Confused thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Defiant behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Elevated mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Emotionally harmed others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Emotionally harmed by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Excessive emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Excessive fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fatigue/low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Grief/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hear strange voices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Homicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Laxative/diuretic use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Obsessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Paranoid thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Physically hurt others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Physically hurt by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Poor grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Seeing strange things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Self-injurious behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sexually harmed others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sexually harmed by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Significant weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Social isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Stuttering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Tics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

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MEDICAL HISTORY - PSYCHOSOCIAL ASSESSMENT

Taking the time to completely fill out this form will help the counselor/therapist best know how to serve you. If you are filling out this form for the client (i.e. a minor child), please list your name: _____

Name of Client: _____ DOB: _____

Presenting Issue or Problem: _____

Who do you talk to and share your thoughts and feelings with? _____

How do you deal with stress? _____

MEDICAL HISTORY

Primary Care Physician: _____ Telephone # (____) _____

Full Address: _____

*Certain insurance plans require the primary care physician to be notified of treatment.

Psychiatrist: _____ Telephone # (____) _____

Full Address: _____

Power of Attorney for Health Care: _____

Current state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List of Medications:

Medication	Prescribing Doctor	Dosage	Frequency

Check ☒ medical/developmental history for the client (C) or in the family (F):

C	F		C	F		C	F	
<input type="checkbox"/>	<input type="checkbox"/>	Accidents: falls, head injury	<input type="checkbox"/>	<input type="checkbox"/>	Dementia/Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid: <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Drug use	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use
<input type="checkbox"/>	<input type="checkbox"/>	Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	Ear infections/tubes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/behavior problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Caffeine use	<input type="checkbox"/>	<input type="checkbox"/>	Food sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Other:

Previous Mental Health Care:

Previous Counselor: _____ Dates of Service: _____

Previous Counselor: _____ Dates of Service: _____

Previous Psychiatrist: _____ Dates of Service: _____

Previous Psychiatrist: _____ Dates of Service: _____

Previous Hospitalization: _____ Dates of Service: _____

Previous Hospitalization: _____ Dates of Service: _____

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FAMILY & RELATIONSHIPS - PSYCHOSOCIAL ASSESSMENT

FAMILY OF ORIGIN

Biological Father / Legal Guardian Name: _____ **General Health:** _____

Occupation: _____ **Strength of Relationship:** _____

Biological Mother / Legal Guardian Name: _____ **General Health:** _____

Occupation: _____ **Strength of Relationship:** _____

Step Father / Other Name: _____ **General Health:** _____

Occupation: _____ **Strength of Relationship:** _____

Step Mother / Other Name: _____ **General Health:** _____

Occupation: _____ **Strength of Relationship:** _____

Siblings / Ages: _____

Describe Family Environment/Experience: _____

FAMILY

Spouse / Significant Other: _____

List Who is Living in the Home / Ages: _____

Describe Current Visitation Arrangements (If Applicable): _____

HISTORY OF RELATIONSHIPS

- | | |
|--|---|
| <input type="checkbox"/> Child | <input type="checkbox"/> Very satisfied with relationship |
| <input type="checkbox"/> Date, currently single | <input type="checkbox"/> Satisfied with relationship |
| <input type="checkbox"/> Date, currently in serious relationship | <input type="checkbox"/> Somewhat satisfied with relationship |
| <input type="checkbox"/> Single, never married | <input type="checkbox"/> Dissatisfied with relationship |
| <input type="checkbox"/> Engaged to be married | |
| <input type="checkbox"/> Married, # of years _____ | |
| <input type="checkbox"/> Married, divorced, # times _____ | |

NOTES REGARDING INTIMATE RELATIONSHIPS

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