ADULT CLIENT PSYCHOSOCIAL ASSESSMENT

Therapist: ____________________ **Intern:** ___________________ **Date:** ___________

Client's Name: ________________________________ **Preferred Name:** ____________________________

Sex: Male ☐ Female ☐ **Date Of Birth**: ____________________ **Age:** _____________

Social Security Number: _______________________ **Referred by:** ___________________________________

Contact Information:

Mailing Address: ____

City: ______________________ State: _______ Zip Code :__________ May we send mail here: □ Yes □ No

Home Address (if different): ____

City: _______________________ State: _______ Zip Code :___________May we send mail here: □ Yes □ No

Home Phone: (_______)___________________________________ May we leave a message here: □ Yes □ No

Cell Phone: (_______)___________________________________ May we leave a message here: □ Yes □ No

Work Phone: (_______)___________________________________ May we leave a message here: □ Yes □ No

Email Address: ____ May we send a message here: □ Yes □ No

Marital Status: *Married* ☐ *Divorced* ☐ *Single* ☐ *Widow* ☐ *Separated* ☐

Why are you seeking therapy at this time? ____
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What would you like to accomplish during therapy? ____
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____

EDUCATIONAL HISTORY:

High School Graduate? Yes ☐ ***or*** No ☐ GED: ☐ **College Level Completed (Circle One):** 1-2-3-4

Degree: ________________________________ **Advanced Degree:** ______________________________

Student: Yes ☐ ***or*** No ☐ **If yes:** Part-time ☐ or Full-time ☐

OCCUPATIONAL HISTORY:

Employed: Yes ☐ ***or*** No ☐ Retired ☐ Disabled ☐

Name of Current Employer: ____

Please check one: Part-time ☐ Full-time ☐ Other ☐

If other, please specify: ____

Length of time with current job: ____

Please list jobs and length of employment for each:

Job Name	Position	Length of Employment	Reason for Leaving
1.			
2.			
3.			
4.			

FAMILY INFORMATION:

Please mark all individuals living in your household (exclude yourself):

Name	Relationship	D.O.B.	Gender
1.			Check One: M ☐ ***or F*** ☐
2.			Check One: M ☐ ***or F*** ☐
3.			Check One: M ☐ ***or F*** ☐
4.			Check One: M ☐ ***or F*** ☐
5.			Check One: M ☐ ***or F*** ☐

Therapist notes: ____

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COUNSELING HISTORY:

Have you ever received counseling, therapy or psychiatric treatment before? Yes ☐ ***or*** No ☐

If yes, please check the following: Outpatient ☐ Day Treatment ☐ Residential ☐ Hospitalization ☐

Dates	Where	Reason	Diagnosis

If you received treatment before, was it helpful? ______________________________
Previous/Current Diagnose(s): ______________________________

Are you currently receiving counseling, therapy or psychiatric treatment? Yes ☐ ***or*** No ☐

If yes, please complete the following:

Dates	Where	Reason	Diagnosis

Previous/Current Diagnose(s): ______________________________

Please list all the medications you are currently taking:

Name	Amount	How Often

Have you ever thought about or attempted suicide? Yes ☐ ***or*** No ☐
If yes, when ____________________ **Please explain:** ____________________
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Please mark the following symptoms that you have had or currently have:

☐ Problems sleeping
☐ Nightmares
☐ Flashbacks
☐ Intrusive memories
☐ Nervousness
☐ Excessive Crying
☐ Stomach Problems

☐ Body image problems
☐ Increase fear
☐ Trust issues
☐ Increased feelings of guilt
☐ Feelings of not being in control
☐ Anxiety
☐ Self-blame

☐ Cutting on self
☐ Problems with intimacy
☐ Startle responses
☐ Increased anger
☐ Mood changes
☐ Panic attacks
☐ Poor self-image

☐ Changes in eating ☐ Panic attacks ☐ Increased sex drive
☐ Daydreaming ☐ Racing Heart ☐ Vomiting

Therapist notes: ____

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Describe how you currently deal with stress: ____

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Describe how you dealt with stress in the past: ____

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<u>EATING HABITS</u>: (***Mark all that apply***)

Current Appetite: ☐ good ☐ fair ☐ poor
Past Appetite: ☐ good ☐ fair ☐ poor
Do you skip meals? ☐ Yes ☐ No
Do you eat a lot? ☐ Yes ☐ No
Do you vomit? ☐ Yes ☐ No
Weight changes/fluctuations? ☐ Yes ☐ No
If yes, please explain: ____

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Do you exercise? ☐ Yes ☐ No
If yes, please describe (exercise/length/frequency): ____

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<u>SUBSTANCE USE HISTORY</u>: (***Indicate all that apply***)

Have you ever used alcohol? Yes ☐ ***or*** No ☐

If yes, please describe below:

Type	Amount	How Often	Age Started	Date Last Used

Describe any problem you have experienced as a result of your use: ____

____

____

Please Check all that apply (If yes, please describe below):

Type	How Much	How Often	Age Started (As Applies)	Date Last Used (As Applies)
Coffee: Yes☐ No☐				
Tea: Yes☐ No☐				
Soda: Yes☐ No☐				
Tobacco Products: Yes☐ No☐				

Do your friends or relatives think you drink too much alcohol, overuse prescription drugs, coffee/tea, or soda? Yes ☐ ***or*** No ☐ **Explain:** ____

Have you ever used drugs such as cocaine, marijuana, heroin, crack, ecstasy, non-prescribed medicine? Yes ☐ ***or*** No ☐

If yes, describe the following:

Type	Amount	How Often	Age Started	Date Last Used

Describe any problem you have experienced as a result of your use: ______________________________
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Therapist notes: ____
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SLEEPING HABITS: (please mark all that apply)

- ☐ Sleep throughout the night
- ☐ Wake-up during the night
- ☐ Difficulty getting to sleep
- ☐ Sleep more than usual
- ☐ Do not feel rested after sleep
- ☐ Dreams: Good/Bad
- ☐ Wake up too early
- ☐ Nightmares
- ☐ Cannot sleep at all
- ☐ Sleep all the time

Number of hours sleep per day: ______________________

MEDICAL HISTORY:

Please mark any of the following physical/medical problems you presently have or have had in the past:

☐ Difficulties being born
☐ Difficulties giving birth
☐ Allergies to medications
☐ Other allergies
☐ Under/Over Weight
☐ High blood pressure
☐ Heart disease
☐ Kidney/bladder/genital
☐ Eyes/ears/nose/throat
☐ Digestive system
☐ Serious childhood illness
☐ Cancer
☐ Diabetes
☐ Thyroid
☐ Epilepsy
☐ Lung disease
☐ Muscles/joints/bones
☐ Blood disease
☐ Nervous system
☐ Migraine headaches
☐ Physical Disability
☐ Broken Bones
☐ Gastro-Intestine
☐ Gynecological
☐ Hypoglycemia
☐ Liver disease
☐ Seizures
☐ Prostate
☐ Developmental problems growing up

List any and all Injuries:

Injury Type	Date

Has anyone in your family had any of the above medical issues?

Condition	Family Member

Therapist notes: ____

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Have you been hit, pushed, restrained, confined, physically coerced, injured, threatened or stalked by a partner/spouse or other? Yes ☐ ***or*** No ☐
If yes, please explain: ____

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Have you ever hit, pushed, restrained, confined, physically coerced, injured, threatened or stalked a partner/spouse or other? Yes ☐ ***or*** No ☐
If yes, please explain: ____

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Are you a veteran? Yes ☐ ***or*** No ☐

LEGAL HISTORY:

Please mark any of the following that applies:

As an Adult:
- ☐ Police involvement
- ☐ Arrests
- ☐ Convictions
- ☐ Probation/parole

As a Juvenile:
- ☐ Police involvement
- ☐ Arrests
- ☐ Convictions
- ☐ Probation/parole

Please explain: ____

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FAMILY BACKGROUND:

Who raised you? ____

Name/Relationship: ____

Your ages(s) when with them: ____

Were you raised in a religious environment? Yes ☐ ***or*** No ☐

If yes, what religion? ____

Did you attend parochial school? Yes ☐ ***or*** No ☐

If yes, how long? ______________________

Please provide the following information in regard to each family member:

Family Member	Name	Age	Occupation	Deceased/Date/Cause
Father				
Mother				
Step-Father				
Step-Mother				
Guardian				
Sibling 1				
Sibling 2				
Sibling 3				
Sibling 4				

Therapist notes: ____

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Family history of symptoms/diagnosis (please mark all that apply for each family member & specify their relationship to you):

Symptom/Diagnosis	You	Family Member	If you checked family member, what is their relation to you?
Depression	☐	☐	
Bipolar	☐	☐	
PTSD	☐	☐	
Anxiety	☐	☐	

Panic Attacks	☐	☐	
Addiction	☐	☐	
Multiple Personalities	☐	☐	
Suicide Attempts	☐	☐	
Suicide Completed	☐	☐	
Schizophrenia	☐	☐	
Mental Retardation	☐	☐	
Incidents of Sexual Abuse:	☐	☐	
Other: (please type out below)			
	☐	☐	

SUPPORT SYSTEM:

Please mark the one which most reflects your current support system: ☐*none* ☐*some* ☐*a lot*

Significant other's name/relationship: ____

Family/Friends/Co-workers: (*please list*)

Name	Relationship
1.	
2.	
3.	
4.	
5.	

Do you participate in social clubs? Yes ☐ ***or*** No ☐

Are you a member of a church/religious group? Yes ☐ ***or*** No ☐

Please list the community agencies you are involved with:

Name of Community Agency	Involvement/Position	How Long?
1.		
2.		
3.		
4.		
5.		

Therapist notes: ____

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Please mark any of the following support groups you attend, how often, and indicate number of meetings:

Type of Meeting	Attended	Meetings per Week
1. Alcoholics Anonymous (AA)	Yes ☐ ***or*** No ☐ ***N/A*** ☐	
2. Narcotics Anonymous (NA)	Yes ☐ ***or*** No ☐ ***N/A*** ☐	
3. Overeaters Anonymous (OA)	Yes ☐ ***or*** No ☐ ***N/A*** ☐	
4. Other: ____________________	Yes ☐ ***or*** No ☐ ***N/A*** ☐	

Please provide any other information that would be helpful for your therapist to know: ________________
____
____

Client's Signature: ____________________________________ **Date:** ___________________________

Licensed Therapist Signature: __________________________ **Date:** ___________________________

For Clinician Use Only

ADULT CLIENT ASSESSMENT

Client's Name: ___________________________________ Date: _______________________________

Clinical Impressions/Intake Summary: ____
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PROVISIONAL DIAGNOSIS

Diagnostic Impressions:
Axis I: ____
Axis II: ____ **ICD – 9 Code:** __________________________
Axis III: ____
Axis IV: ____
Axis V: ____

Current GAF: ____________ **Highest GAF Past Year:** ___________

RECOMMENDATION(S) FOR TREATMENT:
☐ *Group* ☐ *Individual* ☐ *Family* ☐ *Couples* ☐ Other: _______________________________

I concur ☐ OR I do not concur ☐ with the above recommendation(s).

____ ______________

Licensed Therapist's Signature Date