PSYCHOSOCIAL ASSESSMENT

Name: ___________________________ **Intake Date:** _______________ **Date of Birth**______________________

Email: ___________________________ **Phone Number:** ____________ **CID** _____________________________

Mailing Address: ________________________________ **City:** _______________ **State:** ____ **Zip code:** __________

Emergency Contact/Relationship: ________________________________ **Phone Number:** ____________________

Referral Source: _______________________________ **Referral Date:** _____________ **Appointment Time:** _______

Age: _______ **Race:** ____________ **Religious Affiliation:** ______________ **Marital Status:** _________________

Gender Identity: ____________________________ **Sexual Orientation:** ______________________________

Any gender and/or sexual orientation issues? **Yes / No**

If yes, please explain: ____

How often are you involved in religious or spiritual practices? ____

Do you have religious or spiritual beliefs/ strengths? **Yes / No**

If yes, please explain: ____

Do you have religious or spiritual problems? **Yes / No**

If yes, please explain: ____

History of Presenting Problem

Presenting problem: ____

____

____

Alcohol/Drug related issues: ____

____

____

Symptoms, onset, duration, and frequency associated with presenting problem: ___________________________

____

____

____

Psychiatric History

Have you ever had any outpatient counseling? **Yes / No**

If yes, Name of business: ____

Date of services: ____________________________ Length of services: ________________________

Reason for services: ____

Have you ever had inpatient/residential treatment? **Yes / No**

If yes, Name of business: ____

Date of services: ____________________________ Length of services: ________________________

Reason for services: ____

Have you ever had a psychiatric diagnosis in the past? **Yes / No**

If yes, please list: ____

History of Trauma

Have you ever experienced past or current sexual, psychological, or physical abuse or trauma? **Yes / No**

If yes, please explain: ____

Have you ever experienced trauma? **Yes / No**

If yes, please describe the nature of that trauma: ____

____

Date of trauma: ________________ Persons involved: ____

Are you currently taking psychiatric medications? **Yes / No**

If yes, please list medication and dosage: ____

Reason for medication: ______________________________ Prescribing Physician: _________________________

Have you taken psychiatric medications in the past? **Yes / No**

If yes, please list medication and dosage: ____

Reason for medication: _______________________ When? ________________ For how long? ________________

Family Psychiatric History

History of mental illness in family, diagnoses, etc. ____

____
____
____

Medical Conditions and History

Are you currently experiencing any medical conditions (ex. diabetes, heart disease, etc.)? Yes / No

If yes, please list: ____

Comments regarding medical history: ____

____

Do you have any allergies or special precautions? Yes / No

If yes, please list: ____

Do you currently have Tuberculosis (TB)? Yes / No

Have you ever been diagnosed with TB in the past? Yes / No

Number of pregnancies: __________ Number of live births: ____________

Do you take birth control? Yes / No

Birth control method (protection during sex): _______________

Current Medications

Have you taken any medication(s) in the past two weeks? Yes / No

Do you take any medication(s) for any reason? Yes / No

Have you always taken your medication(s) as prescribed in the past? Yes / No

Medication	Dosage/Frequency	Reason prescribed	Reason ended

Substance Use History

Have you ever been in treatment for substance abuse? Yes / No

If yes, Name of business: ____

Date of services: ___________________________ Length of services: _______________________

Reason for services: ____

History of tobacco use? **Yes / No** **Current tobacco use?** **Yes / No**

If yes, tobacco type: ___________________ Age started: __________ Frequency of use: __________________

Number of attempts to quit: _____ Longest length of quit time: _______ Aids used to quit in the past: __________

History of alcohol use? **Yes / No** **Current alcohol use?** **Yes / No**

If yes: ___Never used ___Uses occasionally ___Uses socially ___ Uses regularly ___ Defines as a problem

History of drug use? **Yes / No** **Current drug use?** **Yes / No**

If yes: ___Never used ___Uses occasionally ___Uses socially ___ Uses regularly ___ Defines as a problem

Alcohol or Drug type	Age first used	Total time used (weeks, months, years)	When last used	Amount used	How used	Frequency of use	Dollar amount of weekly use

Do you find yourself using more of your chosen substance? **Yes / No**

Do you suffer from withdrawal when you try to quit? **Yes / No**

Do you use to excess? **Yes / No**

Have you tried to cut down or control your usage? **Yes / No**

Do you find yourself preoccupied with use? **Yes / No**

Has your use diminished your functioning? **Yes / No**

Have you continued to use despite negative consequences? **Yes / No**

Does or has your use:

interfered with you daily life? **Yes / No**

placed you in hazardous situations? **Yes / No**

caused you legal problems? **Yes / No**

caused you interpersonal conflict? **Yes / No**

Family History

By whom were you raised? ____

Parents marital status: Married Divorced Separated Never Married

Was there alcohol or drug use in the home? **Yes / No**

Please describe your upbringing (circle all that apply):

Good/ Happy Home Strict Home Religious Home Unfair Home Abusive Home

Absent Family Multiple Homes Siblings Foster Homes

Homeless Other: ____

Explain: ____

Are significant issues from childhood impacting your current presenting problem? **Yes / No**

If yes, circle all that apply: Trust issues with current relationship Intrusive memories

Ongoing tense relationships w/ family Difficulty w/ activities of daily life

Loss of family w/ residual feelings Difficulty w/ work or school functioning

Explain: ____

Do you have a positive relationship with your parents? **Yes / No**

Do you have a positive relationship with your siblings? **Yes / No**

Family history of substance abuse? **Yes / No**

If yes, please describe: ____

Family history of criminal activity? **Yes / No**

If yes, please describe: ____

Family history of medical problems? **Yes / No**

If yes, please describe: ____

Social History

Current marital status: ________________________ **Number of time married:** ________________________

If married (or in a significant relationship) more than once, explain reason for divorce or separation: ___________

____

Current problems with intimate relationships? **Yes / No**

Describe your relationship with your current partner (circle all that apply):

Positive Negative Abusive Respectful Disrespectful Other: ________________

Comments: ____

Have you been hit, slapped, kicked, or otherwise physically hurt in the past year? **Yes / No**

If yes, please explain: ____

Have *you* hit, slapped, kicked, or otherwise physically hurt someone in the past year? **Yes / No**

If yes, please explain: ____

In the past year, has anyone forced you to have sexual activities? **Yes / No**

If yes, please explain: ____

In the past year, have *you* forced anyone to have sexual activities? **Yes / No**

If yes, please explain: ____

Are you in any way fearful of your partner? **Yes / No**

If yes, please explain: ____

Current living arrangement: ______________________________ Number of persons in the home: _____________

Who are the persons residing in the home? ____

Do you need food, clothing, or shelter? **Yes / No**

Condition of the home: In good condition/ In need of repair Own/ Rent House/Apartment/Mobile home

How many times have you moved in the past two years? _______________

Current home living situation (circle all that apply):

Adequate Comfortable Overcrowded Unstable Homeless Other: ________________

Current home atmosphere Circle all that apply):

Abusive Judgmental Accepting Affectionate Closed Competitive Cooperative

Distant Flexible Helping Inviting Open Warm Rigid

Religious Loving Other: ____

Are you satisfied with your current living situation? **Yes / No**

Do you have children? **Yes / No**

If yes, how many? _________ What are their ages? __________________________________

Do your children live with you? **Yes / No**

Explain: ____

Have your children been removed from your care/ custody? **Yes / No**

If yes, please explain: ____

Are there family issues to be addressed in treatment? **Yes / No**

If yes, please explain: ____

Who makes up your current support system? ____

____

Would you describe your current support system as adequate for you needs? **Yes / No**

Developmental/ Educational History

Do you have a history of developmental delays? **Yes / No**

If yes, please describe: ____

Can you read and write? **Yes / No**

Any difficulties with reading, writing, and/or comprehending? **Yes / No**

How do you learn best: Reading Hands-on Modeling/examples Self-studies

Do you have any problems of an academic nature? **Yes / No**

Were you in special education classes? **Yes / No**

Highest grade completed: __________

Describe how you did in school (circle all that apply):

Good/ Decent Grades	Fair/ Poor Grades	Learning Disability
No Behavior Issues	Some Behavior Issues	Frequent Behavior Issues
Suspended/ Expelled	Dropped Out	Graduated

Other: ____

Are you currently in school/ college/ training program? **Yes / No**

If yes, name and location: ____

Occupational History

Current Employment Status: ____

How long at current job? ____________________ Job title/ Description: _______________________________

Longest period of time on a job? ________________ Job title/ Description: _________________________________

Best/ Favorite Job held? ______________________ How long there? _____________________________________

Why did you leave this job? ____

Do you have problems of a vocational nature? ____

Are you satisfied with your current job? **Yes / No**

Explain: ____

Have you experienced difficulty performing work or work-like activity? **Yes / No**

If yes, explain: ____

Legal History

Have you ever been arrested? **Yes / No**

If yes, how many times? _______ Date(s) of arrest(s): ____

Do you have any *present* legal involvement? **Yes /No**

If yes, please describe: ____

Do you have any *past* legal involvement? **Yes / No**

If yes, please describe: ____

Reason for last incarceration, when, and how long? ____

Are you presently awaiting charges? **Yes / No**

If yes, explain: ____

Is there current DCF or FFN involvement? **Yes / No**

If yes, explain: ____

Has there been a history of DCF or FFN involvement? **Yes / No**

Strengths and Limitations

Please list your strengths (CIRCLE NO MORE THAN 6):

Adventurous	Ambitious	Artistic	Athletic	Logical	Considerate	Cheerful
Creative	Dependable	Drug-free	Easy-going	Friendly	Energetic	Honest
Forgiving	Humorous	Hardworking	Insightful	Humble	Independent	Kind
Intelligent	Likeable	Loyal	Mature	Open-minded	Organized	Tough
Outgoing	Patient	Healthy	Strong	Active	Professional	Relaxed
Reflective	Religious	Reserved	Resourceful	Stable	Observant	Serious
Goal-Oriented	Sensitive	Sympathetic	Tactful	Responsible	Tolerant	Warm
Straightforward	Wholesome	Wise	Resilient	Trustworthy		

Please list your weaknesses (CIRCLE NO MORE THAN 6):

Fearful	Pushy	Loose-tongued	Mistrustful	Undisciplined	Sloppy	Rude
Disapproving	Short-sighted	Narrow-minded	Inflexible	Bossy	Passive	Blunt
Aggressive	Chaotic	Cynical	Dramatic	Vague	Moody	Naïve
Stand-offish	Indifferent	Wasteful	Stubborn	Reckless	Inhibited	Greedy
Fanatical	Dull/Boring	Arrogant	Lazy	Intolerant	Impatient	Selfish
Complaining	Shallow	Strict	Prejudiced	Resentful	Shy	Hard

Unforgiving Other: ____

Please list your needs: ____

Please list your abilities: ____

Please describe any leisure activities or hobbies: ____

Are there any barriers or challenges to treatment (circle all that apply)?

Aggression Anger Childcare Cultural Beliefs Family Members Pregnancy

Transportation Living Conditions High Anxiety Medical Complications Severe Depression

Past Counseling Experience Substance Abuse

Have you ever attempted suicide? **Yes / No**

If yes, was the attempt aborted or interrupted? ____

If yes, please explain when, how, and number of attempt(s): ___________________________________

____

____

Have you wished to be dead or have had suicidal thoughts, in the past week? **Yes / No**

If yes, do you have a method and/ or plan? ____

Have you ever committed self-injurious behavior? **Yes / No**

If yes, please to either please explain: ____

____

Have you ever engaged in setting fires? **Yes / No**

Have you ever engaged in animal cruelty? **Yes / No**

Have you ever self-harmed in a non-suicidal way (i.e. cutting, burning, picking, etc.)? **Yes / No**

If yes, please explain: ____

Do you have any thoughts of harming someone else? **Yes / No**

If yes, do you have a method or a plan? ____

Have you ever harmed or attempted to harm someone else? **Yes / No**

If yes, please explain: ____

Treatment Plan

What goal(s) would you like to accomplish while in treatment?

Goal 1: Please finish this sentence: **"I want to** ____

____

What are the steps you think are needed or necessary to accomplish this goal? ____________________________

____

Goal 2: Please finish this sentence: **"I want to** ____

____

What are the steps you think are needed or necessary to accomplish this goal? ____________________________

____

Would you like your family involved in your treatment? **Yes / No**

Client, please print, sign, and date here for initial treatment plan:

____

Client (print name)

____ ______________________

Client Signature **Date**

____

Counselor (print name)

____ ______________________

Counselor Signature **Date**

LAST THREE PAGES ARE FOR STAFF USE ONLY

Mental Status Exam

Appearance	Obese Over-weight Under-weight Emaciated Bizarre hair style Unshaven Unnatural hair color Wounds Scars Tattoos Disheveled Soiled Body odor Halitosis Underdressed Overdressed Bizarre Militaristic Appropriate for setting
Behavior	Walk with: Limp Shuffle Assisted Gait/March Aggressive Cataplexy Psychomotor Agitation Hyperactivity Tic Other:
Speech	Rapid Slow Slurred Mumble Stutters Loud Whispered Hesitant Emotional Monotonous Stereotypical Unspontaneous Talkative Responsive Mutism Other:
Attitude to Examiner	Seductive Playful Ingratiating Friendly Cooperative Interested Attentive Frank Indifferent Evasive Defensive Hostile
Mood and Affect	Ecstatic Euphoric Expansive Elevated Euthymic Dysphoric Anhedonia Depressed Grieving Panicked Fearful Anxious Tense Agitated Apathetic Irritable Anger Other:
Affective Expression	Normal Restricted Blunted Flat
Appropriateness	Appropriate Inappropriate Labile
Hallucinations	Auditory Visual Olfactory
Thought Process	Goal-directed Logical Disorganized Other:
Orientation	Oriented x3 Other:
Memory/ Concentration	Short-term Intact Distractable/Inattentive Other:
Insight/ Judgement	Good Fair Poor

Stage of Change:

ASAM Placement:

Diagnosis:

Methods of Assessment: Examination materials include autobiographical data, review of collateral information from intake forms, assessment inventories, the DSM-5, and clinical interview.
Assessment inventories include the Columbia-Suicide Severity Rating; the PHQ-9 & GAD 7; the Intoxicated and/or Drunk Questionnaire; and the Alcohol Use Disorders Identification Test: Interview Version (AUDIT).
Client's Columbia-Suicide Severity Rating indicates ________ current or past suicidal/homicidal thoughts, intent, ideation, or attempts. Client list protective factors as (circle all that apply): identifies reasons for living, responsibility to family or other, supportive social network or family, Fear of death or dying due to pain and suffering, belief that suicide is immoral; high spirituality, and/or engaged in work or school.
Client's PHQ-9 score ____ out of 27 indicates _________ depression and the GAD-7 score of ____ out of 21 indicates ________ anxiety. The Intoxicated and/or Drunk Questionnaire and AUDIT indicates _______alcohol or drug use.

Clinical Summary (Identify problems that led to placement/behavior patterns that need to be addressed in treatment. Assess and list strengths and weaknesses in the area of work/education, economics, psychology, society, and health, as these relate to the client's needs. Identify safety, legal, medical, spiritual, and financial issues or factors that may affect treatment):

Recommendations:

Based on the information obtained in this screening it is determined that (circle one)**:**

Client is appropriate for services at this agency

Client is appropriate for referral to: ______________

Client is not appropriate for services at this agency

Client is not in need of services at this time

Client given orientation information

_______________________________________ _________________
Signature/ Credentials of Screener Date

_______________________________________ _________________
Licensed Clinician/ LMHC CAP Date

CLINICIAN NOTES

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