

PSYCHOSOCIAL ASSESSMENT

Name: _____ Age: _____ Sex: _____

DIRECTIONS: Please answer the following questions as fully as possible.

What event(s) have prompted you to seek counseling?

When did these problems develop? _____

Problem Assessment:

Present Problem/Stressors: *Please circle all that apply:*

Marital/Relational Health Issues Grief/Loss Job/Career Financial
Parent/Child Past Issues (abuse, neglect, childhood/family of origin issues)
Other _____

Symptoms: *Please circle all that apply:*

Sleep Problems Depressed Mood Mood Swings
Energy Loss/Fatigue Shy/Lonely Alcohol/Drug Issues
Decreased Concentration Worry/Obsessing Sexual Concerns
Decreased Motivation Fear/Panic Disturbing Thoughts
Appetite Changes Anger Problems Thoughts of Death
Other _____

Suicidal/Homicidal Ideation:

Have you attempted to commit suicide or homicide in the past? yes no
Is there a history of suicide in your nuclear and/or extended family? yes no
Have you ever inflicted burns or wounds to yourself? yes no
Are you presently suicidal/homicidal? yes no
Any other risk taking behaviors that you engage in? yes no

Psychiatric History:

Have you ever had any previous outpatient counseling? yes no

If yes, list dates, length of time and reason: _____

Was it helpful? yes no How so? _____

Have you ever been admitted to the hospital for mental health or addiction issues? yes no

If yes, list dates, places and reason: _____

Was it helpful? yes no How so? _____

List all current medications you are taking for anxiety, depression, sleep, etc: _____

List all medications you have taken *in the past* for anxiety, depression, sleep, etc: _____

Medical Information:

How would you describe your current condition of health? _____

Do you have any disabilities and/or health problems? yes no

If yes, explain: _____

Substance Use History:

Describe your current and past usage of the following substances:

Substance	Amount	Frequency	Age 1 st Use	Age Regular Use Started	Last Use
tobacco	_____	_____	_____	_____	_____
alcohol	_____	_____	_____	_____	_____
marijuana	_____	_____	_____	_____	_____
cocaine	_____	_____	_____	_____	_____
stimulant	_____	_____	_____	_____	_____
opiates	_____	_____	_____	_____	_____
other	_____	_____	_____	_____	_____

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

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

Do you use laxatives, water pills, or diet medications to control your weight? yes no

Do you or others believe you exercise excessively? yes no

Educational History:

What was school like for you? _____

Highest Level Achieved: _____ What type of grades did you make? _____

ADHD? yes no Learning Disabilities? yes no

Currently in school? yes no If yes, what level? _____

Work History:

Current Job/Career: _____

What do you enjoy about this job/career? _____

What do you dislike about this job/career? _____

Describe your relationship 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 had in the last five years? _____

Military History:

List branch, dates, and duties:

Financial Situation:

Describe briefly your financial situation: _____

Developmental History:

How would you describe your childhood? Traumatic Painful Uneventful Good /Happy
What were you like as a child (include friends, school, hobbies, and personality)?

List members of your childhood family and comment on how you got along with each one:

Name	Relationship	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What was your birth order? _____ of _____ children Who primarily raised you? _____
Were there any unusual or traumatic experiences for you as a child?

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 towards another person? yes no
If yes, please explain: _____
Have you ever had an abortion? yes no
What is your sexual orientation? Heterosexual Homosexual Bisexual

Marital History (if applicable):

When were you married? _____ Name and age of spouse: _____
What is your perception of your current marriage (strengths, weaknesses, communication, etc.)?

Previous marriages(s): yes no Name and Dates: _____

List names and ages of children and how you get along with each:

Name	Age	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Religious/Cultural Factors:

What is your religious background? _____
Do you currently attend church, synagogue, or mosque? 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? _____

Social Relationships/Support System:

What are your hobbies or leisure activities? _____

Do you have any close friends? yes no If yes, describe: _____

Who do you rely on for support? _____

Would it be beneficial for any members of your family/friends to be involved in your treatment?
 yes no

If yes, explain who and how/why: _____

What is your family's perception of your difficulties? _____

Miscellaneous:

Are there any other things that can be helpful for us to know about you? _____

List your strengths and weaknesses:

Strengths

Weaknesses

What would you like to accomplish during your treatment? _____

Signature: _____

Date: _____

Clinician: _____

Date: _____

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