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: _____

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	☐	☐	☐	☐	☐		
Agitation	☐	☐	☐	☐	☐		
Alcohol use	☐	☐	☐	☐	☐		
Anorexia	☐	☐	☐	☐	☐		
Anxiety	☐	☐	☐	☐	☐		
Appetite disturbance	☐	☐	☐	☐	☐		
Behavior problems	☐	☐	☐	☐	☐		
Binging/purging	☐	☐	☐	☐	☐		
Bowel/bladder disturbance	☐	☐	☐	☐	☐		
Compulsive behaviors	☐	☐	☐	☐	☐		
Confused thinking	☐	☐	☐	☐	☐		
Defiant behaviors	☐	☐	☐	☐	☐		
Depressed mood	☐	☐	☐	☐	☐		
Drug use	☐	☐	☐	☐	☐		
Elevated mood	☐	☐	☐	☐	☐		
Emotionally harmed others	☐	☐	☐	☐	☐		
Emotionally harmed by others	☐	☐	☐	☐	☐		
Excessive emotions	☐	☐	☐	☐	☐		
Excessive fears	☐	☐	☐	☐	☐		
Fatigue/low energy	☐	☐	☐	☐	☐		
Grief/loss	☐	☐	☐	☐	☐		
Guilt	☐	☐	☐	☐	☐		
Hear strange voices	☐	☐	☐	☐	☐		
Hopeless	☐	☐	☐	☐	☐		
Homicidal thoughts	☐	☐	☐	☐	☐		
Hyperactivity	☐	☐	☐	☐	☐		
Irritability	☐	☐	☐	☐	☐		
Laxative/diuretic use	☐	☐	☐	☐	☐		
Mood swings	☐	☐	☐	☐	☐		
Obsessions	☐	☐	☐	☐	☐		
Panic attacks	☐	☐	☐	☐	☐		
Paranoid thoughts	☐	☐	☐	☐	☐		
Physically hurt others	☐	☐	☐	☐	☐		
Physically hurt by others	☐	☐	☐	☐	☐		
Poor concentration	☐	☐	☐	☐	☐		
Poor grooming	☐	☐	☐	☐	☐		
Seeing strange things	☐	☐	☐	☐	☐		
Self-injurious behaviors	☐	☐	☐	☐	☐		
Sexual dysfunction	☐	☐	☐	☐	☐		
Sexually harmed others	☐	☐	☐	☐	☐		
Sexually harmed by others	☐	☐	☐	☐	☐		
Significant weight gain/loss	☐	☐	☐	☐	☐		
Sleep disturbance	☐	☐	☐	☐	☐		
Social isolation	☐	☐	☐	☐	☐		
Stuttering	☐	☐	☐	☐	☐		
Suicidal thoughts	☐	☐	☐	☐	☐		
Tics	☐	☐	☐	☐	☐		
Worry	☐	☐	☐	☐	☐		
Other:	☐	☐	☐	☐	☐		
Other:	☐	☐	☐	☐	☐		

Last Name	First	Middle	Date	Client #

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

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

- ☐ Child
- ☐ Date, currently single
- ☐ Date, currently in serious relationship
- ☐ Single, never married
- ☐ Engaged to be married
- ☐ Married, # of years _____
- ☐ Married, divorced, # times _____

- ☐ Very satisfied with relationship
- ☐ Satisfied with relationship
- ☐ Somewhat satisfied with relationship
- ☐ Dissatisfied with relationship

NOTES REGARDING INTIMATE RELATIONSHIPS