Adult Psychosocial Assessment

Name___________________________________ DOB__________________________

PRESENTING PROBLEM: What brings you here today?

____

____

Mental Health History

Please circle all that apply to you (choose severity that applies):

(0) Not Present, (1) Mild, (2) Moderate, or (3) Severe)

Depression	**0 1 2 3**			Panic Attacks	**0 1 2 3**
Anxiety	**0 1 2 3**	Memory Problems	**0 1 2 3**	Obsessive Thoughts	**0 1 2 3**
Mood Swings	**0 1 2 3**	Loss of Interest	**0 1 2 3**	Ritualistic Behavior	**0 1 2 3**
Appetite Changes	**0 1 2 3**	Irritability	**0 1 2 3**	Checking	**0 1 2 3**
Sleep Changes	**0 1 2 3**	Excessive Worry	**0 1 2 3**	Counting	**0 1 2 3**
Hallucinations	**0 1 2 3**	Suicidal Ideation	**0 1 2 3**	Self-Injury	**0 1 2 3**
Work Problems	**0 1 2 3**	Relationship Issues	**0 1 2 3**	Difficulty	
Racing Thoughts	**0 1 2 3**	Low Energy	**0 1 2 3**	Concentrating	**0 1 2 3**
Confusion	**0 1 2 3**			Hyperactivity	**0 1 2 3**

Describe a brief history of your present symptoms:

____

____

What effect have they had on your life?

____

____

Have you ever been treated for a mental health problem? If yes, please describe:

____

____

Have you ever had a mental health hospitalization? ___No ___ Yes, please describe:

____

Medical History

Previous surgeries/Major Illness/Medical Diagnoses (please include reason and year)

____
____

Please list any additional health information that may be important for your therapist to know (including any medication or other allergies or problems with pain):

____
____

List daily medications and Dosages (including over the counter medications)

Current Medication	Dosage	Prescribing Physician	Last Dose	Taking as Prescribed?

Are you having any difficulty with pain? No____ Yes; please describe:
____
____

Are there any guns in your home? ___ No ____ Yes

Have you ever:

Binged on food? _________ Gone without eating? ___________ Vomited on purpose?________

Used laxatives to purge? ________

Marital/Social Relationships

Are you: ___ Single ___ In a relationship ___Married ___ Divorced ___ Separated ___ Widowed

How many times have you been married? ______ Dates of previous marriages? _____________

Do you have any concerns regarding your marriage or relationship?

____
____

Do you have any children? ___ No ___Yes; how many? _____ Please list their sex and ages:

____

____

Do you regularly engage in social activities? ___ No ___ Yes

Do you have a social support network? ___ No ___Yes

Family History

Describe the family in which you were raised:

____

____

Describe your current relationship with your family of origin:

____

____

Is there any history of mental health or substance abuse problems in your family? ___No ___Yes:
Please explain:

____

____

Did you experience any physical, emotional, or sexual trauma in your childhood? ____No _____Yes

If yes, please explain:

____

____

Educational History:

How far did you go in school? ____

Did you have any learning or behavioral issues in school? ___ No ____Yes; please explain:

____

____

Work History

Do you work? ____No _____Yes If Yes:

Name of Employer _________________________________ Length of Employment ________________

Do you like your job? Why or why not? ____

Substance Use

Do you use tobacco? ___No ___Yes, amount per day? ____ How many years at this frequency?______

Do you use alcohol? ___No ___Yes, what type? ______________ Frequency?______________

When was your last drink? ______________ How much? _________________

Have you ever experienced any form of withdrawal symptoms, such as hallucinations, tremors, excessive sweating, nausea, or vomiting? ____No _____ Yes; please explain:

____

____

Have your ever experienced blackouts? ____No ____ Yes, how frequently? ______________________

Have you ever used illicit drugs or taken more medication than prescribed? ___No ____ Yes; what type?____

Frequency? __________________________________ Date of last use: __________________________

If you are not presently using, have you ever used in the past? ___ No ____ Yes; What types of alcohol or other substances have you used? ____
Frequency? ______________________ Last used: ____

Have you ever received treatment for substance abuse? ____ No _____ Yes; Name of agency, type of treatment, and dates:

____

____

Have you ever been involved in any recovery or support programs? ___ No ____ Yes; please explain:

____

____

Are you aware of your triggers to drink or use? ____ No ____ Yes; please explain:

____

____

Have you ever had any legal issues related to the use of alcohol or other drugs? ___ No ___ Yes; please explain, including name of offense and dates:

____

____

Client Signature **Date**