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Please complete and bring to your first session

Psychosocial Questionnaire and Assessment

Client Name: ______________________________Therapist: _____________________________
Client Age: _____________ Date of Birth: _______________ Date of Intake________________

Describe the problem or situation that brought you to counseling:
____
____
____
____
____
When did you first notice the problem? ____
How often is the problem occurring? ____

Please indicate the problems that you are experiencing:

Anger	____	Excitability	____	Mania	____
Alcohol problems	____	Fatigue	____	Numb feelings	____
Anxiety	____	Gambling problems	____	Obsessive	____
Appetite disturbance	___	Hallucinations	____	Panic attacks	____
Avoiding people	____	Heart palpitations	____	Phobias/fears	____
Compulsive behavior	___	Hopeless feelings	____	Recurrent thoughts	____
Depressed mood	____	Hyperventilating	____	Relationship problems	__
Disorganized thoughts	__	Impulsivity	____	Self harm	____
Distractible	____	Irritability	____	Sexual problems	____
Dizziness	____	Judgment errors	____	Sleep problems	____
Drug problems	____	Loneliness	____	Suicidal thoughts	____
Eating habits	____	Memory problems	____	Worry	____
Elevated mood	____	Mood changes	____	Other (specify)	________

Briefly explain if/how the problems are effecting your life (Work, school, relationships, etc.):
____
____
____
____

List stressful situations, events, experiences and other relevant information over the past 12 months that may be contributing to the problem(s):

Please describe any trauma (extremely stressful events) that you can recall experiencing at any time of your life. This may include experiencing or witness to physical, emotional, psychological and/or sexual abuse, being involved in very high stress situations for long periods of time, involved in accidents, witness to sudden death, military combat situations, etc.:

What are your personal strengths (skills, talents, gifts, traits, etc.)?

Who do you turn to for support (specific individuals, groups, church, etc.)?

What are your goals for therapy?

Family of Origin:

Who were (are) your primary caregivers? ______________________________

Describe your relationship with your caregivers:

Do you have Siblings? Please give names and ages and a brief description of the quality of therelationship:

Has anyone in your family of origin (parents, grandparents, siblings, etc.) ever suffered from mental health problems? Please indicate who and the extent of the known problem:

____
____
____

Other relevant family of origin history: ______________________________________
____
____
____

Marital and Current Family/Relationship Dynamics:

Single _________

Married ________ Spouse's name and length of marriage__________________________

Divorced________ Name(s) of former spouse(s) and dates of marriage(s) _____________
____

Widowed________ Please indicate length of marriage, spouses name and date of death___
____

Current committed relationship, not married______________ Cohabitating? __________

Please indicate name of partner and length of relationship________________________

Children (names and ages) ____
____

Medical History

Do you have a primary care physician? No_____ Yes ________

Name and Location of primary physician: _____________________________________
____

Any other physicians involved with your care? ________________________________
____

Please describe any significant physical health problems:

____
____
____
____
____
____

Current mediations, doses, other treatments and purpose:

____
____
____

Psychological/Mental Health History

Please describe any past mental health diagnosis, approximate dates when diagnosed, previous hospitalizations, psychiatric treatment etc:

____
____
____
____

Current psychiatric or psychotherapeutic treatments and providers involved:

____
____
____

Current medications including doses and prescribing physician:

____
____
____

Chemical Use History

Please check the following substances that you have used in the past 1 year.
Alcohol ____ Marijuana _____ Cocaine/Crack ____Meth ____Inhalants ___ Stimulants____
Hallucinogens ____ Heroin/Opiates _____ Prescription pain medications or other narcotics (indicate) ________________ Other____
How many times per week/month do you use alcohol?____________________________
How many times per week/month do you use other drugs? (please list drug and frequency)____
How many servings do you have at a time? ______________________________________
Have your ever felt like you should cut down on your drinking or drug use? ______________
Have people ever annoyed you by criticizing your drinking or drug use? ________________
Have you ever felt guilty about your drinking or drug use? ___________________________
Have you ever had a drink or used drugs first thing in the morning in order to get started for the day, steady your nerves, or get rid of a hangover or residual drug effect? ____________
Have you ever been in trouble with the law as a result of your chemical use? ____________
Have you ever been treated for chemical abuse/dependency? Yes ________ No _________
If yes, indicate dates and facilities____
Is there a family history of chemical abuse/dependency? Yes __________ No ____________
If yes, please specify____

Education History

How many years of formal education do you have? _________________________________
High School Diploma ______ B.A. /B.S. degree(s) _________________________________
Graduate degree(s)__________________________Other:____________________________
Are you currently in school? _______ What school do you attend? ____________________
Is the current problem effecting your academic performance? Yes ________ No __________
If yes, please describe: ____
____

Have you been diagnosed with a learning disability (describe)? ________________________
____

Have you been diagnosed with ADD/ADHD?_______________________________________

Work History

Are you currently working? Yes__________ No__________

What type of work do you do? ____

Past work experiences____

____

Have there been any recent changes to your employment status? __________________

Has the current problem affected your work performance? If yes, please describe:

____

____

____

Military History

Have you ever been in the military? Yes ________ No_________ Active? ______________

What branch? _________ Please describe any combat experience and location:__________

____

Type of discharge________________________ Rank at discharge__________________

Recreation

Describe activities that you do as a form of recreation or relaxation: __________________

____

____

____

Describe activities and interests that you wish to further develop: __________________

____

____

____

Spiritual/Religious

Do you associate with a particular spiritual or religious denomination or group?

No _____ Yes______ (please specify) ____

Is the current problem affecting your spiritual life? No _____Yes_____ (explain) __________

____

Would you like to incorporate your spiritual beliefs in therapy? No_______ Yes __________

Please describe how we may help integrate your faith into therapy____________________

____

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