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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_____

_____

_____

_____