PSYCHOSOCIAL ASSESSMENT

Name: ________________________ **Intake Date:** _______________ **Date of Birth**: _______________

Email: _________________________ **Phone Number:** _____________ **SSN** _______________________

Mailing Address: _________________________ **City:** _______________ **State:** ______ **Zip:** __________

Emergency Contact Name/Relationship: ________________________ **Phone Number**: _______________

Referral Source: _________________________ **Referral Date:** _______ **Appointment Time:** ____________

Presenting Problem

Issues not substance related: ____

____

____

____

Alcohol/drug related issues: ____

____

____

____

Are you ordered to enter into treatment? Y ____ N ____

If so, by (organization): _____________ Officer's name: _____________ Officer's Phone No: _____________

Does your alcohol or drug use occur at (Highlight all that applies):

Home School Work With Friends All the time Other _____________

How often do these problems occur? ____

How long have you had these problems? ____

Office Use Only:

Presenting Problem Continued

Have these problems gotten worse since they began? ____________________

Have these problems ever decreased or gone away? ____________________

What has occurred in the past month that has caused or increase these problems? ____________________

What made you decide to seek counseling at this time? ____________________

Behavioral Health History

Have you ever had any outpatient counseling? Y ____ N ____

If yes, Name of business: ____________________

Date of services: ____________ Length of services: ____________________

Reason for services: ____________________

Have you ever had inpatient/residential treatment? Y ____ N ____

If yes, Name of business: ____________________

Date of services: ____________ Length of services: ____________________

Reason for services: ____________________

Have you ever been in treatment for substance abuse? Y ____ N ____

If yes, Name of business: ____________________

Date of services: ____________ Length of services: ____________________

Reason for services: ____________________

Are you currently taking psychiatric medications? Y ____ N ____

If yes, type of medication(s) and dose: ____________________

Reason you are taking medication: ____________________

Prescribing physician: ____________________

Have you taken psychiatric medication in the past? Y ____ N ____

If yes, specify type(s): ____________________

When? ____________ For how long? ____________________

Office Use Only:

Name: ____________________ **Client ID:** ____________________

Is there a family history of mental health problems? Y ____ N ____

Describe: ____

Substance Use History

History of tobacco use: Y ____ N ____

Current tobacco use: Y ____ N ____ **Age started:** _______

If yes, Tobacco type: ____

How many smoked daily? ______________________ **Amount Chewed, Dipped, or Vaped daily?** ____________

Number of attempts to quit: ___________________ **Longest length of quit time:** ________________________

Have you used aids in the past to quit smoking (Chew, Dip, Patch, Gum, Zyban, etc)?: Y N

If yes, what? ____

Client's report of use of alcohol or other substances is:

____Never used ____Uses occasionally ____Uses socially ____Uses regularly ____Defines as problem

Alcohol or Drug type	Age first used	Total time used (weeks, months/, or years)	When last used	Amount used	How used	Frequency of use (per week)	Dollar amount of weekly use

(please highlight one):

Do you find yourself using more of your chosen substance? Yes No

Do you suffer from withdrawal when you try to quit? Yes No

Do you use to excess? Yes No

Have you tried to cut down or control your usage? Yes No

Do you find yourself preoccupied with use? Yes No

Has your use diminished your functioning? Yes No

Have you continued to use despite negative consequences? Yes No

Does or has your use *(please highlight one):*

Interfere with your daily life? Yes No

Place you in hazardous situations? Yes No

Cause you legal problems? Yes No

Cause you interpersonal conflict? Yes No

How many days per week do you have more than 2 alcoholic drinks? ________

Medical information

Have you taken any medications(s) in the last two weeks? Yes No

Do you take any medications(s) for any reason? Yes No

Have you always taken your medication(s) as prescribed in the past? Yes No

Medication(s) taken (list all)

Name	Dosage/frequency	Reason prescribed	Reason ended

Medical History

(List all that applies below):

Breathing Problems Heart Disease Infectious Disease Impaired Speech

Diabetes High Blood Pressure Impaired Ability to Walk Impaired Vision

Gastrointestinal Problems High Cholesterol Impaired Hearing Liver Problems

Obesity Seizure Disorder Ulcer Other ________________________

All that applies:

Do you currently have Tuberculosis (TB) Yes No

Have you ever been diagnosed with TB in the past? Yes No

Comments regarding medical history ____

Number of pregnancies: ____ Number of live births: ____ Birth *control* Yes No

Birth control method (protection during sex): ____________________

Any allergies or special precautions? Yes No

If yes, specify: ____

Special Needs

Do you have any specials needs that are currently being met? Yes No

If yes, how? ____

Are there any special needs that we may assist with providing you quality care? Yes No

If yes, what? ____

Office Use Only:

Name: ________________________ **Client ID:** ________________________

Family History

By whom were you raised? ____

To describe your upbringing ***please list all that applies below):***

Parents Divorced	Parents Never Married	Parents Separated	Parents Remarried
Parents Deceased	No Involvement w/ Biological Parents		Raised by Grandparents
Raised by Others	Good/Happy Home	Strict Home	Religious Home
Unfair Home	Abusive Home	Absent Family	Multiple Homes
Alcoholic Home	Drug Abuse Home	Siblings	Foster Homes
Homeless	Other: ______________________		

Explain: ____

Are significant issues from childhood impacting current presenting problem? Yes No

If yes, list all that applies below:

Trust issues with current relationship	Intrusive memories
Ongoing tense relationships w/ family	Difficulty w/ activities of daily life
Loss of family w/ residual feelings	Difficulty w/work or school functioning

Explain: ____

Do you have a positive relationship with your parents? Yes No

Do you have a positive relationship with your siblings? Yes No

Do any family members have a history of mental illness? Yes No

If yes, how are you related? ____

Describe mental illness: ____

Family history of substance abuse? Yes_ No

If yes, explain: ____

Family history of criminal activity? Yes No

If yes, explain: ____

Family history of medical problems? Yes No

If yes, explain: ____

Intimate Relationship and Current Living Situation

Current marital status: ________________________ Number of times married: ___________

If married (or in a significant relationship) more than once, explain reason for divorce or separation: ___________

____

Current problems with intimate relationships? Yes ____ No ____

Describe your relationship with your current partner. ***List all that applies in the "comments" section.***

Positive Negative Abusive Respectful Disrespectful Other: ________________

Comments: ____

Within the last year, **have you been** hit, slapped, kicked, or otherwise physically hurt by someone? ____________

If yes, please explain ____

Within the last year, **have you** hit, slapped, kicked, or otherwise physically hurt by someone? ____________

If yes, please explain ____

Within the last year, **has anyone forced you** to have sexual activities? ______________________________

If yes, please explain ____

Within the last year, **have you forced anyone** to have sexual activities? ______________________________

If yes, please explain ____

Are you in any way fearful of your partner? Yes ____ No ____

If yes, please explain ____

Current living arrangement:

Number of persons, other than you, living in the home: _____

Who are they? ____

Do you need food, clothing, or shelter? Yes _____ No ____

Condition of home: In good condition In need of repair Own Rent House Apartment

How many times have you moved in the last two years? ____________

Current Home Atmosphere *(List all that applies):*

Abusive Accepting Affectionate Closed Cold Competitive

Cooperative Crowded Distant Flexible Helping Inviting

Judgmental Loving Open Rigid Religious Warm

Atmosphere: ____

Current Living Situation *(Check all that applies):*

Adequate Comfortable Homeless Unstable Other: ______________________

Overcrowded Are you satisfied with your current living Yes No

situation? Yes No

Do you have children? How many? What are their ages? ________________________________

Do your children live with you? Yes No

Explain: ____

Have your children been removed from your care/ custody? Yes No

If yes, why? ____

Are there family issues to be addressed in treatment? Yes No

Explain: ____

Cultural, Gender, and Spiritual Considerations

What is your racial identity? ____________________

What is your gender identity? ____________________

What is your sexual orientation? Heterosexual Homosexual Bisexual Other: ________

Do you identify with a particular cultural group? Yes No

If yes, describe group: ____________________

Any gender and/or sexual orientation issues? Yes No

If yes, describe the issues: ____________________

Primary Religious Affiliation *(Highlight all that applies):*

Baptist Buddhist Catholic Episcopalian Hindu Lutheran

Methodist Inter-denominational Muslim None Protestant

Other-Christian Other Non-Christian Unknown Other: ________

Describe religious or spiritual beliefs and practices: ____________________

How often are you involved in religious or spiritual practices? ____________________

Do you have spiritual strengths? Yes No

Do you have spiritual problems? Yes No

Educational and Developmental Information

Do you have any problems of an academic nature? Yes No

Are you currently in school/college/training program? Yes No

If so, name and location of school: ____________________

Were you in special education classes? Yes No

Highest grade completed: ________

How do you learn best? ***(Highlight all that applies):*** Reading Hands-on Modeling/examples Self-studies

Other: ________

Describe how you did in school *(Highlight all that applies):*

Good/Decent Grades Fair/Poor Grades Retained Learning Disability

No Behavior Issues Some Behavior Issues Frequent Behavior Issues

Suspended/Expelled Dropped Out Other: ________

Can you read and write? Yes No

Any difficulties with reading, writing, and/or comprehending? Yes No

If yes, explain: ____________________

Do you have a history of developmental delay? Yes No

If yes, explain: ____________________

Vocational Information

Current employment status *(List all that applies):*

Active Duty Military | Disabled | Employed Full-Time | Employed Part-Time

Full-Time Student | Part-Time Student | Retired | Unemployed -Seeking

Unemployed – Not Seeking | Other: ____________________

How long at current job? ________ Job title/description: ____________________

Longest period of time on one job? ________ Job title/description: ____________________

Best/favorite job held? ____________________ How long there? ____________________

Why did you leave that job? ____________________

Do you have problems of a vocational nature? Yes No

Are you satisfied with your current job? Yes No

If yes, explain: ____________________

Have you experienced difficulty performing work or work-like activity? Yes No

If yes, explain: ____________________

Financial Status

Source of income or support received during past 12 months *(Highlight all that applies):*

Children | Disability | Illegal Activity | Loans | None

Parents | Retirement | Social Security | Wages | Other: ____________

Do you currently have financial problems? Yes No

If yes, explain: ____________________

Legal History

Have you ever been arrested? Yes No

If yes, how many times? ________ Date(s) of arrest(s): ____________________

Do you have any **present** legal involvement? Yes No

If yes, ***Highlight all that applies:*** Arrested/Not Convicted | Assault | Awaiting Sentence

Awaiting Trial | Convicted/Served Time | Deferred Adjudication | Deferred Prosecution

Drug/Alcohol Offense | On Bail | On Parole | On Probation | Sex Offender

Do you have any **past** legal involvement? Yes No

If yes, ***Highlight all that applies:*** Arrested, Not Convicted | Assault | Awaiting Sentence

Awaiting Trial Convicted, Served Time Deferred Adjudication Deferred Prosecution

Drug/Alcohol Offense On Bail On Parole On Probation Sex Offender

Reason for last incarceration, when and how long? ______________________________

Are you presently awaiting charges, trial or sentence? Yes No

If yes, explain: ______________________________

Last arrested for (offense): ______________________________

Is there current DCF or FFN involvement? Yes No

If yes, explain: ______________________________

Has there been history of DCF or FFN involvement? Yes No

High Risk Behaviors

Have you ever engaged in setting fires? Yes No

Have you engaged in animal cruelty? Yes No

Have you ever attempted suicide? Yes No

If yes, was the attempt aborted or interrupted? ______________ (which one)

Please explain when, how, and number of attempted(s): ______________________________

Have you wished to be dead or have had suicidal thoughts, in the past month? Yes No

If yes, do you have a method and/or plan? Yes No

Have you ever self-harm in a non-suicidal way (i.e., cutting, burning, picking, etc.) Yes No

If yes, please explain: ______________________________

Do you have any thoughts have harming someone else? Yes No

If yes, do you have a method and/or plan? Yes No

Have you ever harmed or attempted to harm someone else? Yes No

If yes, please explain: ______________________________

Have you ever experienced past or current sexual, psychological or physical abuse or trauma? Yes No

If yes, please explain: ______________________________

Support System

Who makes up your current support system? *Check all that applies:*

Boy/Girlfriend Co-workers Extended Family Friends Spouse/Partner

Immediate Family Online Friends Religious Organization Self-help Group Pet(s)

Social Services Group Teachers Counselor None Other: ______________

Would you describe your current support system as adequate for your needs? Yes No

Strengths/Weaknesses

Please list your strengths. ***Select no more than 6 qualities:***

Adventurous	Ambitious	Artistic	Athletic	Logical	Cheerful	Considerate
Creative	Dependable	Drug-free	Easy-going	Friendly	Energetic	Forgiving
Humorous	Hardworking	Insightful	Honest	Humble	Independent	Intelligent
Kind	Likeable	Loyal	Mature	Organized	Outgoing	Observant
Patient	Healthy	Goal-oriented	Strong	Active	Tough	Straightforward
Professional	Reflective	Relaxed	Religious	Reserved	Resourceful	Open-minded
Sensitive	Serious	Stable	Tactful	Responsible	Tolerant	Sympathetic
Trustworthy	Warm	Wholesome	Wise	Resilient		

Please list your weaknesses. ***Select no more than 6 qualities:***

Fearful	Pushy	Loose-tongued	Mistrustful	Undisciplined	Sloppy
Rude	Disapproving	Short-sighted	Narrow-minded	Inflexible	Bossy
Passive	Aggressive	Chaotic	Cynical	Dramatic	Blunt
Stand-offish	Vague	Moody	Indifferent	Uncaring	Intolerant
Wasteful	Stubborn	Reckless	Inhibited	Naïve	Greedy
Fanatical	Dull/Boring	Arrogant	Lazy	Selfish	Complaining
Impatient	Hard	Shallow	Strict	Shy	Prejudiced
Resentful	Unforgiving	Other:	________________________		

Please list your needs: ____

Please list your abilities: ____

Describe any leisure activities or hobbies: ____

Are there any barriers or challenges to treatment? Yes No

If yes*, list all that applies below:*

Anger	Aggression	Childcare	Cultural Beliefs	Family Members	Pregnancy
Transportation	Living Conditions		High Anxiety	Medical Complications	
Severe Depression	Past Counseling Experience		Substance Abuse	Other: _____________________	

Treatment Plan

What goal(s) would you like to accomplish while in treatment?

Goal One: Please finish this sentence: I want to "______________________________

____

What are the steps you think are needed or necessary to accomplish this goal? ______________

____

Goal Two: Please finish this sentence: I want to "______________________________

____

What are the steps you think are needed or necessary to accomplish this goal? ______________

____

Would you like your family involved in your treatment? Yes No

If yes, explain: ____

Client, please print, sign, and date here for initial treatment plan:

______________________________ ______________

Client (print name) Date

____

Client Signature

______________________________ ______________

Counselor (print name) Date

____

Counselor Signature

PLEASE STOP HERE

(Final section for staff member only)

Mental Status Exam

Appearance	Obese Over-weight Under-weight Emaciated Bizarre Hair Style Unnatural Hair Color Unshaven Wounds Scars Tattoos Disheveled Soiled Body Odor Halitosis Underdressed Overdressed Bizarre Militaristic Appropriate for Setting
Behavior	Walk with: Limp Shuffle Assisted Gait/March Aggressive Cataplexy Psychomotor Agitation Hyperactivity Tic Other:
Speech	Rapid Slow Slurred Mumbled Stutters Loud Whispered Hesitant Emotional Monotonous Stereotypical Unspontaneous Talkative Responsive Mutism Other:
Attitude to Examiner	Seductive Playful Ingratiating Friendly Cooperative Interested Attentive Frank Indifferent Evasive Defensive Hostile
Mood and Affect	Ecstatic Euphoric Expansive Elevated Euthymic Dysphoric Anhedonia Depressed Grieving Panicked Fearful Anxious Tense Agitated Apathetic Irritable Anger Other:
Affective Expression	Normal Restricted Blunted Flat
Appropriateness	Appropriate Inappropriate Labile
Hallucinations	Auditory Visual Olfactory
Thought Process	Goal-directed Logical Disorganized Other:
Thought Process	Delusions Obsessions/compulsions Phobias Other:
Orientation	Oriented x 3 Other:
Memory/Concentration	Short Term Intact Long Term Intact Distractible/Inattentive Other:
Insight/Judgment	Good Fair Poor

Stage of Change:

ASAM placement:

DIAGNOSIS:

METHODS OF ASSESSMENT: Examination materials include autobiographical data, review of collateral information from intake forms, assessment inventories, the DSM-5, and clinical interview.

Assessment inventories include the Columbia-Suicide Severity Rating; the PHQ-9 & GAD-7; the Intoxicated and/or Drunk Questionnaire; and the Alcohol Use Disorders Identification Test: Inerview Version (AUDIT).

Client’s Columbia-Suicide Severity Rating indicates no current or past suicidal/homicidal thoughts, intent, ideation, or attempts. Client’s protective factors are: identifies reasons for living; responsibility to family; supportive social network; belief that death is immoral; and engaged in work. Client’s PHQ-9 score of __ (of 27) indicates ________ depression and GAD-7 score of __ (of 21) indicates ________ anxiety. Client’s Intoxicated and/or Drunk Questionnaire indicates __________ substance use concern. AUDIT score of __ indicates _______ alcohol or drug use, in Zone __.

CLINICAL SUMMARY: (Identify problems that led to placement/behavior patterns that need to be addressed in treatment. Assess and list strengths and weaknesses in the areas of work/education, economics, psychology, society, and health, as these relate to the client’s needs. Identify safety, legal, medical, spiritual, and financial issues or factors that may affect treatment):

RECOMMENDATIONS:

Based on the information obtained in this screening it is determined that *(highlight one):*

Client is not in need of services at this time.

Client is appropriate for services at this agency.

Client is not appropriate for services at this agency.

Client is appropriate for referral to: _____________________

Client given orientation information.

____ ______________________

Signature/Credentials of Screener Date

____ ______________________

LMHC CAP SAP Date