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PSYCHOSOCIAL EVALUATION AND ASSESSMENT - ADULT

INTAKE DATE: ____/____/____

IDENTIFYING INFORMATION

NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ GENDER: _____
_____ RACE : _____
_____ HEIGHT: _____
HOME PHONE: (____)_____ WEIGHT: _____
WORK PHONE: (____)_____ EYE COLOR: _____
CELL PHONE: (____)_____ HAIR COLOR: _____
OCCUPATION: _____
MARITAL STATUS: _____ EDUCATION LEVEL:_____
IN CASE OF EMERGENCY, CONTACT_____
PHONE NUMBER: (____)_____

PRESENTING PROBLEM

Please circle the issue(s) for which you are seeing treatment; double-circle the primary or most pressing issue:

a. Marriage	b. Anxiety/worry	c. Depression	d. Family Problems
e. Relationship	f. Sexual Issues	g. Loneliness	h. Self-Confidence
i. Alcohol	j. Drugs	k. Physical (ill/tired)	l. Moodiness
m. Legal	n. Financial	o. Work/job/career	p. Concentration
q. Anger	r. Eating	s. Sleeping	t. Trauma
u. Grief/loss	v. Memory Problems	w. Social Problems	x. Other

Please explain: _____
_____

How much has this problem affected your life? (Circle the best answer)

1	2	3	4	5	6	7	8	9	10
very little									a great deal

HISTORY OF PRESENTING PROBLEM

1. Please describe the reason or events that led up to this problem: _____

2. Approximately how long has this problem existed for you? _____

3. How frequently does this problem interfere with your life? _____

4. Have you received treatment for this problem? If yes, when, where and with whom? _____

5. How have you tried to resolve, improve or cope with this issue? _____

FAMILY OF ORIGIN INFORMATION

1. Please provide the following information (as applicable):

	NAME	AGE	EDUCATION	OCCUPATION
FATHER				
STEPFATHER				
FOSTER FATHER				
MOTHER				
STEPMOTHER				
FOSTER MOTHER				
GUARDIAN				
GUARDIAN				

2. Please provide, in birth order, the following information about your brothers and sisters (living or deceased). Include yourself within the list where appropriate.

NAME	AGE	OCCUPATION	ADDRESS(CITY,STATE)

3. Who were your adult, primary caregivers? (Circle all that apply)
   a. Both parents
   b. Father (___alone ____with step-mother
   c. Mother (___alone ___with step-father)
   d. Relatives (Specify _____)
   e. Adoptive parents
   f. Foster parents
   g. Other (Specify _____)

4. With whom did you live while you were growing up?
   _____
   _____
   _____
   _____

5. What words best describe your mother or the primary female, adult caregiver? **(Circle all that apply.)**

a. Warm	b. Rejecting	c. Understanding
d. Distant	e. Overprotective	f. Perfect
g. Uncaring	h. Domineering	i. Affectionate
j Strict	k. Abusive	l. Other_____

6. What words best describe your father or the primary, male adult caregiver? **(Circle all that apply.)**

a. Warm	b. Rejecting	c. Understanding
d. Distant	e. Overprotective	f. Perfect
g. Uncaring	h. Domineering	i. Affectionate
j Strict	k. Abusive	l. Other_____

7. How would you describe the relationship between your parents? If someone other than both parents raised you, please answer based upon the individuals you believe were the most significant in raising you. **(Circle all that apply)**

a. Close	b. Full of conflict	c. Domineering
d. Cold	e. Hot and cold	f. Loving
g. Ideal	h. Reserved	i. Hostile
j. Strict	k. Distant	l. Other: _____

8. What did your parents (or the individuals who raised you) argue about? **(Circle all that apply).**

a. Money	b. Drinking	c. Neglecting the home
d. Discipline of children	e. Sex.	f. Being a poor provider
g. Relatives, in-laws	h. Jealousy	i. Other: _____

9. How would you describe your childhood? **(Circle all that apply.)**

a. Happy b. Dull c. Painful
d. Frightening e. Hard to remember f. Regimented
g. Unhappy h. Secure i. Other: _____

10. How would you describe yourself as a child? **(Circle all that apply.)**

a. Outgoing b. Friendly c. Stubborn
d. Shy e. Emotional f. Unhappy
g. Active h. Irresponsible i. Calm
j. Aggressive k. Nervous l. Temperamental
m. Awkward n. Rebellious o. Self-Confident
p. Happy q. Serious r. Other: _____

11. How would you describe the method of discipline used by your mother (or the woman most responsible for discipline)? **(Circle the closest answer.)**

a. Strict b. Fairly strict c. Fair
d. Lenient e. Inconsistent

12. How would you describe the method of discipline used by your father (or the man most responsible for discipline)? **(Circle the closet answer.)**

a. Strict b. Fairly strict c. Fair
d. Lenient e. Inconsistent

13. What were problems for you as a child? **(Circle all that apply.)**

a. None b. Getting along with mother
c. Getting along with father d. Getting along with siblings
e. Getting along with peers f. Getting along with teachers
g. Bedwetting h. Nightmares
i. Academics/Schoolwork j. Physical or medical problems
k. Nerves l. Feeling like a burden to parents
m. Overweight n. Underweight
o. Over sensitivity (feelings easily hurt)
p. Fear of failure q. Other: _____

13.a) If desired or necessary, please provide additional explanation of the problems you experienced as a child.

_____
_____
_____

14. What fears did you have as a child? **(Circle all that apply.)**

a. No significant fears b. Death c. Might fail
d. Might get seriously ill e. Might be laughed at f. Might be abandoned
g. Animals h. Other children i. Might lose parents
j. Other: _____

14.a) If desired or necessary, please provide additional explanation of the fears you had as a child.

_____

_____

_____

15. Did you witness or experience any type of abuse (physical, sexual, emotional, etc.) in your family? If yes, please describe the circumstances.

_____

_____

_____

_____

16. Were there any other significant events and/or traumas in your family? If yes, please describe the circumstances. _____

_____

_____

_____

CURRENT FAMILY INFORMATION

1. What is your marital status? **(Circle one).**
   a. Married b. Divorced c. Separated
   d. Widowed e. Single (relationship) f. Single (no relationship)

2. Have you ever been married before? Yes No
   If yes, date of marriage _____ Date of divorce_____

3. How long have you been with your current partner? _____Years _____months

4. Please provide the following information about your children (as applicable)

NAME	AGE	EDUCATION	OCCUPATION	LIVING WITH YOU	
				YES	**NO**
				YES	**NO**
				YES	**NO**
				YES	**NO**

5. Are you having problems with your children's behaviors? Yes No
   If yes, please explain. _____

_____

_____

_____

6. How would you describe your partner? **(Circle all that apply.)**

a. Warm	b. Abusive	c. Boring	
d. Unhappy	e. Faultfinding	f. Stimulating	
g. Distant	h. Understanding	i. Unforgiving	
j. Uncaring	k. Perfect	l Tense	
m. Happy	n. Indifferent	o. Affectionate	
p. Unpleasant	q. Argumentative	r. Does not apply	s. Enjoyable

7. How often do you and your partner argue? **(Circle one.)**

a. Never	b. Once a week	c. Several times a day
d. Rarely	e. Several times a week	f. Does not apply

8. Has your relationship ever been threatened by an affair? **(Circle all that apply.)**

a. No b. Yes, my affair c. Yes, my partner's affair

9. Are you having any sexual problems? Yes No
If yes, please describe. _____
_____
_____

10a. Your current alcohol and/or drug use (amount, type, frequency): _____
_____
_____

10b. Spouse or partner's current alcohol &/or drug use (amt, type, frequency):
_____
_____

11. Have your children or your spouse ever been abused (physically, sexually, or emotionally)? If yes, please describe the circumstances. _____
_____
_____

12. Have your children or your spouse ever experienced a psychological problem? If yes, please describe the circumstances. _____
_____
_____

13. Are there any past or present legal issues? Yes / No

a. Nature of alleged complaint(s): _____
_____

b. Do you have or plan to obtain legal representation?: _____
_____

c. Court date? _____

PSYCHIATRIC/MEDICAL HISTORY

1. Have you had any previous psychological treatment or hospitalizations for any other problems? If yes, when, where, and with whom?

   _____
   _____
   _____

2. Has anyone in your family (immediate family, family of origin, or extended family) suffered from psychological problems?

   a. Suicide
   b. Attempted suicide
   c. Depression (mild, moderate, or severe)
   d. Manic-depression/bipolar
   e. Anxiety
   f. Schizophrenia
   g. Delusions
   h. Hallucinations
   i. Illegal or prescription drug abuse or dependency

If yes, who, what, when, and how treated? Please note any hospitalizations for treatment.

_____
_____
_____
_____

3. Does anyone in your family have an alcohol or drug (illegal or prescription) abuse or dependency Problem? If yes, who, what, and when? Please include any treatment and hospitalization information.

   _____

4. Please provide the information of your family doctors and/or specialists:

NAME	SPECIALTY	CITY, STATE	PHONE #	LAST VISIT(YR,MONTH)

5. Please circle the appropriate answers if you have experienced any of the following within the past Year. If yes, please explain below.

a. YES	NO	Eye disease, injury, and poor vision	**b.** YES	NO	Liver, gallbladder disease
c. YES	NO	Ear disease, injury, and poor hearing	**d.** YES	NO	Bowel disease
e. YES	NO	Nose, sinus, mouth, and throat trouble	**f.** YES	NO	Constipation or diarrhea
g. YES	NO	Hemorrhoids, rectal bleeding	**h.** YES	NO	Venereal disease
i. YES	NO	Fainting spells	**j.** YES	NO	Head injury
k. YES	NO	Loss of consciousness	l. YES	NO	Difficulty falling asleep
m. YES	NO	Convulsions or seizures	**n.** YES	NO	Difficulty staying awake
o. YES	NO	Frequent or severe headaches	**p** YES	NO	Marked weight loss
q. YES	NO	Memory problems	**r.** YES	NO	Marked weight gain
s. YES	NO	Extreme tiredness or weakness	**t.** YES	NO	Mouth or gum disease
u. YES	NO	Neck stiffness, pain, swelling	**v.** YES	NO	Swollen glands
w. YES	NO	Enlarged thyroid or goiter	**x.** YES	NO	Poor appetite
y. YES	NO	Skin disease	**z.** YES	NO	Circulatory problems
aa. YES	NO	Chronic or frequent cough	**bb.** YES	NO	Diabetes
cc. YES	NO	Chest pain or angina pectoris	**dd.** YES	NO	Heart disease
ee. YES	NO	Shortness of breath	**ff** YES	NO	Blood disease
gg. YES	NO	Swelling of hands, feet, ankles	**hh.** YES	NO	Tuberculosis/TB
ii. YES	NO	High blood pressure	**jj.** YES	NO	Hepatitis
kk YES	NO	Back, arm, leg, or joint problems	**ll.** YES	NO	Stomach trouble
mm YES	NO	Premenstrual syndrome/PMS	**nn** YES	NO	Other Chronic Illness

_____

_____

_____

_____

2. Do you eat a balanced diet? Yes No

3. Do you participate in a regular exercise program? Yes No

4. Do you smoke? Yes No
   If yes, how much? _____

5.How would you characterize your size? **(Circle the closest answer.)**

   a. Very thin b. Thin c. About average
   d. A little overweight e. Overweight f. Very overweight

6. Please provide information about medications, prescription or over-the-counter which you take regularly.

CURRENT MEDICATIONS	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Please list any allergies: _____

8. Are you experiencing any difficulties sleeping (i.e. lack of sleep, trouble falling asleep or waking early, dreams)? _____
_____

9. Are you experiencing difficulties with eating (i.e. lack of appetite, increased appetite, restricting food, junk food, etc)? _____
_____

CAREER/EDUCATIONAL HISTORY:

1. Please note all schools you have attended:

Elementary School: _____ City, State: _____
_____ City, State: _____
Middle School: _____ City, State: _____
_____ City, State: _____
High School: _____ City, State: _____
_____ City, State: _____

Describe post-secondary high school training including college or technical training, graduate school, etc:

School: _____ Major/Focus: _____ Degree: _____
School: _____ Major/Focus: _____ Degree: _____
School: _____ Major/Focus: _____ Degree: _____

2. How did you perform academically (above average, average, below average)?
_____
_____

3. Please describe any educational or learning-related difficulties you experienced as a child or as an adult: _____
_____

4. EMPLOYMENT/CAREER

Current job/title: _____
Employer: _____
Length of time at present job: _____
Are you satisfied in your current employment? _____
Please describe any current job or career-related concerns: _____
_____

Please describe past employment/history (jobs, approximate duration of employment, lack of employment):_____

OTHER

1. Please describe any current or past financial difficulties for you or your family_____

2. Are you experiencing any social difficulties (i.e. conflicts, lack of friends)?

3a. Please describe your religious or spiritual upbringing and present belief system (if applicable):_____

3b. Please note any past or current spiritual struggles/concerns:_____

COUNSELING/THERAPY GOALS

1. What changes would you like to see as a result of counseling or therapy? Please list the three to five most important, beginning with the most important.

a. _____

b. _____

c. _____

d. _____

e. _____

2. How will we know when your goals are being met? Please describe the best you can. _____

_____

_____

THANK YOU FOR YOUR ASSISTANCE AND PATIENCE IN COMPLETING THIS FORM

Client Signature: _____

Date: _____