Psycho-Social Assessment

Basic Information

Date:

Client's name:

Social Security Number:

Date of Birth:

Gender:

Ethnicity:

Home Address:

Home phone number: Can we leave a message? Y/N

Work phone number: Can we leave a message? Y/N

Mobile phone number: Can we leave a message? Y/N

If the above client is a minor, please complete the following

Guardian's name:

Guardian's address:

Guardian's phone number: Can we leave a message? Y/N

If you will be using insurance to cover your sessions or a portion of the cost, please fill out the following and allow us to make a copy of your insurance card

Primary Insurance Company:

Secondary Insurance Company (if applicable):

Who referred you to Olive Tree Counseling, or how did you hear about us?

Emergency Contact Information

Name:

Relationship to client:

Address:

Phone number:

History

Who is providing this information? (please circle)

1. The client
2. The client's guardian
3. Other (name: __________________)

Please describe the current problem in your own words, using the best of your abilities (use as much space as you want or need)

How long have you experienced this problem? When did you first notice this problem?

What stressors might contributed to the onset of this problem (symptoms)?

Please check all words/phrases that describe your symptoms, or current emotional /physiological state of being:

Depression (feeling sad/down)

Low energy levels

Irritability

Weight change

Sleep disturbances

Difficulty enjoying things once enjoyed

Crying

Decreased motivation

Social isolation

Thoughts of death/suicide

Plan to commit suicide

Previous suicide attempts

Mood swings

Increase in energy

Reduced need for sleep

Poor concentration

Hallucinations (seeing, hearing, smelling, tasting, feeling things that aren't there)

Delusions (beliefs that others find strange or unbelievable)

Paranoid thoughts (thoughts that you are being watched or spied on)

Homicidal thoughts

Plan

Legal issues

Anxious/nervous/tense

Change in appetite

Racing thoughts

Unwanted thoughts

Muscle tension/aches

Flashbacks/nightmares

Ritualistic behaviors (counting things, washing hands, overly concerned about germs, checking locks/doors/stove)

Indecisiveness about career

Other (please describe)

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___

___

___

Treatment History

Have you participated in or received therapy in the past? Y/N

What did you like/dislike about that experience?

What was helpful?

Is there any type of treatment that you would like to continue?

Have you ever been hospitalized for psychiatric reasons? Y/N

Substance use/abuse? Y/N

If yes, please list the substance, amount used, frequency of use, first time used, and last time used.

Developmental History

Are you aware of any complications/difficulties when your mother was pregnant with you? Y/N

If yes, please explain.

Did you talk/walk/read on time? Y/N

If no, please explain:

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Medical History

Please list any current or important past psychotropic medications

Medication	Dose	Frequency

Have you experienced any head injuries? Y/N

History of childhood illnesses:

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Current health concerns/issues?

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History of serious illnesses, conditions, major operations, seizures?

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How would you rate your current medical health?

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____

Name, address, and phone number of your primary care physician?

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____

____

Date of your last physical?

Family History

Birth Location:

Raised by:

Relationship with parent figures:

Mother:____

Father:____

Step parent:____

Other :____

How many siblings do you have? Describe your relationship with them:

Any history of neglect, physical, sexual, verbal, emotional abuse? Y/N

Please list family history of substance abuse and mental health issues:

Additional family information:

Social History

Describe your relationships with friends/peers:

How would you describe your social support network?

Describe your hobbies/interests:

Describe any cultural concerns:

Educational History

What is the highest educational level you have completed?

Please give any additional important educational information :

Have you ever been diagnosed with a learning disability? Y/N

Employment History

What is your current employment status?

Are you satisfied with your employment? Y/N

If not, why?

Are you interested in pursuing a new career? Y/N

Are you interested in completing assessments that can assist you in choosing a career that is the right fit for you? Y/N

Marital History

What is your marital status? (please circle) Married Single Divorced Seperated Widowed

Are you currently in a relationship? Y/N

Please describe the nature of your relationship:

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How would you rate your marital/relationship satisfaction? (please circle)

Poor Fair Good Great

Please describe any other significant relationships:

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Do you have children? Y/N

If yes, what how would you describe your relationship with your child/children?

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Additional Information

What are your goals for therapy?

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What expectations do you have for therapy?

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____

Name five things that you would like to change about yourself:

1.

2.

3.

4.

5.

What are your strengths/weaknesses?

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Is there any additional information that you believe is important for your therapist to know in order to provide you with the best care possible?

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_______________________ _______________

Client Signature Date