209-A Swanton Way, Suite 102
Decatur, GA 30030
678-587-8084

Psychosocial Assessment Information-Adult

Name________________________________ Birth Date ___/___/___ Age ____ Sex ❑ M ❑ F

Person Completing Form__________________________ Relationship:

Presenting Problem

Briefly describe issue/problems which led to your decision to seek services: ______________________________________

____

____

____

How severe do you rate the presenting problem on a scale of 1 – 10 with 10 being the most severe? (please circle one)

1 2 3 4 5 6 7 8 9 10

How long has this problem been causing distress? (please circle one)

One Week One Month 1 – 6 Months 6 Months – 1 Year Longer Than One Year

In what setting does this problem cause distress? (circle all that apply)

Home School Work Community

How do you rate your ability to cope with problem on a scale of 1 – 10 with 1 being the least able to cope? (please circle one)

1 2 3 4 5 6 7 8 9 10

Do you have concerns about the following areas? (check all apply)

☐ Change in sleep patterns ☐ Change in appetite ☐ Hygiene/Grooming ☐ Work Performance

☐ Concentration ☐ Social relationships ☐ Mood ☐ Behavior

If so, describe ____

____

____

____

MEDICAL HISTORY

How would you describe your overall health? ____

Do you have any health concerns? ☐Yes ☐No If yes, please describe ______________________________

____

Do you have any recurrent medical conditions? ☐Yes ☐No If yes, please describe

____

____

Primary Care Provider ______________________ Phone No. __________ ☐None ☐Unknown

Do you take any medications? ☐Yes ☐No If yes, please list including psychotropic, over-the-counter and herbal supplements

Medication	Dosage	Frequency	Prescribed By	Reason for Medication

Are you taking the medications as prescribed? ☐Yes ☐No If No, please explain ______________________

____

Have you ever had any serious accidents/illnesses or hospitalizations ☐Yes ☐No If yes, please describe below:

____

____

PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Are your child currently being seen by a counselor? ☐Yes ☐No

If yes, name of current counselor ______________________ Length of Treatment __________

Are you currently being seen by a psychiatrist? ☐Yes ☐No

If yes, name of current psychiatrist ______________________ Length of Treatment __________

Have you ever been diagnosed with a mental illness, emotional or psychological condition? ☐Yes ☐No If yes,

What was the diagnosis? ________________ When? __________ By Whom? __________

Have you ever received counseling services, received emergency room care or been hospitalized for mental illness or drug/alcohol

concerns in the past ☐Yes ☐No If yes, please provide dates of service and reason for treatment ________________

____

FAMILY HISTORY

Spouse's Name: ____ Age:_____ # of years married:_____

Currently Employed ☐Yes ☐No

Occupation: ____

Employer: ____

☐ Children

☐ Children at home

Names/Ages:____

____

Any parenting conflicts: ____

____

Are there custody and/or visitation orders are in place? ☐Yes ☐No If yes, **a copy will be needed for the client's record.**

List names, gender, ages and relationships of immediate family members. Please include all members currently living in household.

Name	Gender	Age	Relationship (biological, step, half, etc.)	Lives with child
______________________	____	____	______________________	☐Yes ☐No
______________________	____	____	______________________	☐Yes ☐No
______________________	____	____	______________________	☐Yes ☐No
______________________	____	____	______________________	☐Yes ☐No
______________________	____	____	______________________	☐Yes ☐No

Do you consider anyone else to be a "parent" in your children's life? ☐Yes ☐No If yes, whom?______________________________

Describe your relationship with your child/children: ____

What do you find most challenging about parenting, if anything? ______________________________________

What kind of discipline works best with your child/children? ______________________________________

If applicable, describe your children's relationship with each other: ______________________________

____

Describe any recent changes in the family system (i.e., change in home location, major events or illness, significant losses, etc.)

____

____

Family Concerns: (check if appropriate)

___	Marital Difficulties	___	Death in Family	___	Aging Grandparents	___	Job Loss
___	Drug Addiction	___	Alcoholism	___	Financial Problems	___	Single Parent
___	Serious Illnesses	___	Birth of New Child	___	Other please specify ______________________		

Please check to identify if any family members have a history of any of the following:

		Relationship to you			Relationship to you
___	Depression	________________	___	Trauma History	________________
___	Anxiety	________________	___	Domestic Violence Victim	________________
___	Bipolar DO	________________	___	Alcohol Use/Abuse	________________
___	Schizophrenia	________________	___	Drug Use/Abuse	________________
___	ADHD/ADD	________________	___	Incarceration	________________

ACADEMIC/PROFESSIONAL HISTORY

Did you complete high school? ☐Yes ☐No If no, what was the last year of school you completed? ________

Did you attend college or advanced studies? ☐Yes ☐No If yes, Degree/Subject: ____

Are you satisfied with your achievements/progress? Have you reached the personal goals you set? _________________________

____

____

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____

HOUSING

Do you consider your housing to be: ☐stable ☐unstable If unstable, please describe ________________________________

____

Please choose the one that best describes the current housing arrangement for this child:

☐Owns home ☐Rents home ☐Resides with relatives/friends (temporary)

☐Homeless ☐Emergency Shelter ☐Resides with relatives/friends (permanently)

How long have you lived in the current living situation? ____

How many times have you moved in the past two years? ____

SUPPORT SYSTEM

Do you have a support system (people you can call on for help)? ☐Yes ☐No If yes, who: _________________________________

____

____

CULTURAL/SPIRITUAL PREFERENCES

Do you have any cultural or spiritual preferences? ☐Yes ☐No If yes, describe ____

____

____

____

____

____

RISK ASSESSMENT

Please check any of the following that describe how you believe your child has been feeling lately:

____ sad	____ anxious	____ depressed	____frightened	____guilty	____angry	____aggressive
____ ashamed	____ resentful	____ worthless	____tearful	____irritable	____confused	____ extreme ups/downs
____ jealous	____ hopeless	____helpless	____ frustrated	____ worried	____ shy	____ impulsive

Has you ever **considered suicide in connection** with this/these **current** problem(s)? ☐Yes ☐No ☐Do not know

If yes, please give a brief description with dates: ____

Has you ever **attempted suicide or had thoughts of hurting others** in the **past**? ☐Yes ☐No ☐Do not know _______________

____

ALCOHOL/DRUG ASSESSMENT

Do you use tobacco or smokeless tobacco? ☐Yes ☐No ☐Do not know

Do you use alcohol or drugs? ☐Yes ☐No ☐Do not know

Have you ever used medications (prescription drugs or over the counter medication) for recreational purposes?

☐Yes ☐No ☐Do not know – If yes describe: ____

If yes to any portion of the alcohol/drug assessment, please use the space below to provide details about drug(s) of choice, amount and frequency of use, period of sobriety or prior courses of treatment:

STRENGTHS/RESOURCES

What limitations/barriers do you/does your family have?____
____

What strengths do you/does your family have?____
____

What resources do you/does your family have to help with your current problem/concerns?___________________________________
____

____

____

CURRENT NEEDS/GOALS

What do you feel is your biggest need right now? ____

____

What do you most hope you child will gain from coming to counseling?____

____

If you could pick three (3) goals for to work on in counseling, what would they be?

Goal 1: ____

Goal 2: ____

Goal 3: ____

Is there any additional information you would like for me to know?

____

____

____

____ _________________________________

Printed name of person completing this form **Relationship**

____ _________________________________

Signature **Date**