

Psychosocial Assessment

Shania Chandy, M.A., LPC

Name: _____ Date: _____

Gender: _____ Age: _____

The following assessment will assist me in helping you by providing me with a thorough understanding of you and your specific needs. Please answer the following questions as fully and honestly as possible. If you have any questions or concerns, please ask.

What are the main problems or events that have led you to seek counseling now?

When did these problems develop? _____

Current problems (please circle all that are applicable):

Marital/Relational

Health Issues

Grief/Loss

Job/Career issues

Financial struggles

Parent/Child issues

Past Issues (abuse, guilt, family of origin issues)

Spiritual struggles

Other: _____

Symptoms (please circle all that apply):

Sleep Problems

Decreased Energy/Fatigue

Difficulty Concentrating

Decreased Motivation

Appetite Changes

Depressed Mood

Anxiety/Worry/Panic

Stress

Loneliness

Anger Problems

Mood Swings

Addiction Issues (Alcohol, Drug, or other)

Sexual Concerns

Disturbing Thoughts

Thoughts of Death

Other: _____

Strengths/Weaknesses:

What are your greatest strengths? _____

What are your greatest weaknesses? _____

On a scale of 1-5 (5 is high), how satisfied are you with yourself? _____

On a scale of 1-5, how satisfied are you with your current life? _____

Suicide/Homicide Assessment

Have you ever attempted to commit suicide or homicide in the past? _____

Please explain: _____

Is there are history of suicide in your family? _____

Have you ever inflicted wounds on yourself? _____

Are you presently suicidal or homicidal? _____

Do you have other risk taking behaviors that you engage in? _____

Psychiatric/Medical History:

Please list any current or previous experience seeing a psychiatrist, seeing a counselor or psychologist, or being hospitalized for a mental health or addiction issue:

Date (Approximate)	Name of Provider/Facility	Reason for Treatment	Outcome (what helped and why)

How would you describe your current condition of health? _____

Do you have any disabilities or health problems? _____

Please list any medication for anxiety, depression, sleep, etc. you currently take or have taken in the past: _____

Please list any family history of addiction or emotional struggles: _____

Have you ever had an abortion (for males, has a child of yours ever been aborted)? _____

If yes, date(s): _____

Substance Use History:

Do you use any of the following?

Substance:	Yes	No	Amount	Frequency:	Date Last Used:
Tobacco	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____	_____
Amphetamines	_____	_____	_____	_____	_____
LSD	_____	_____	_____	_____	_____
Heroin	_____	_____	_____	_____	_____
Pain Killers	_____	_____	_____	_____	_____
IV Drug Use	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

Has there been a recent increase in your use of any of these substances? _____

Do you, your family, or your friends see your current usage as a problem? _____

Nutrition:

Do you have balanced, healthy eating patterns? _____

Do you have concerns about your weight and shape? _____

Do you tend to eat out of depression, boredom, or anger? _____

Do you ever binge eat or fear losing control of your eating? _____

Do you ever self-induce vomiting? _____

Do you use laxatives, diuretics, or diet medication for weight control? _____

Do you or others believe you exercise excessively? _____

Legal History:

Do you have any history with the legal system including charges as a minor, present charges, arrests, bankruptcy, civil suits, probation, parole, or child custody problems?

Please explain briefly. _____

Military History:

If applicable, please list branch, dates, and duties. _____

Educational History:

What was school like for you? _____

Highest level achieved: _____

What type of grades did you make? _____

Were you ever diagnosed with a learning disability or ADHD or do you suspect you should have been diagnosed? _____

Are you currently in school? _____

Work History:

What is your current job/career? _____

What do you like/dislike about your job? _____

How do you get along with authority figures and co-workers? _____

Have you ever been fired or laid off? _____

Describe your current level of job performance. _____

How many jobs have you had in the last 5 years? _____

Financial:

Briefly describe your financial situation: _____

Developmental History:

Where were you born and raised? _____

Circle words you would use to describe your childhood:

Traumatic Painful Uneventful Good/Happy Other: _____

What were you like as a child (include friends, school, hobbies, personality)? _____

What was your birth order? ____ of ____ children.

Who primarily raised you? _____

What is the marital status of your parents? _____

List members of your childhood family and describe your relationship with each one:

Name	Relationship	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Were there any unusual or traumatic experiences for you as a child?

Age	Event
_____	_____
_____	_____
_____	_____

Who or what would you consider positive influences on your development? _____

Have you ever been the recipient of unwanted sexual acts? _____

Have you ever been the victim of abuse, neglect, or violence? _____

Have you ever been the perpetrator of abuse toward another person? _____

What is your sexual orientation? _____

Current Living Arrangements:

Is your current living situation satisfactory or unsatisfactory? _____

Where do you live? _____ How long there? _____

With whom do you live? _____

Marital History (if applicable):

If currently married, how long have you been married? _____

Name and age of spouse: _____

What is your spouse's occupation? _____

What is your perception of your current marriage (communication, strengths, weaknesses, etc.)? _____

Please list dates of any previous marriages: _____

Children (if applicable):

Please list names and ages of children and comment of your relationship with each one.

Name	Age	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social Relationships and Support System:

Who can you rely on for support? _____

Do you have close friendships? _____ Please describe: _____

What are your hobbies or leisure activities? _____

Would it be beneficial for your spouse (if applicable) or any other family members to be involved in your treatment? _____ Please explain: _____

What is your family's perception of your difficulties? _____

Religious/Cultural Factors:

What is your religious background? _____

What is your cultural background? _____

Describe the influence of religious and cultural factors in your home, both in the past and currently: _____

Do you currently attend church, synagogue, mosque, or other place of worship? _____

If yes, where? _____

What does God seem like to you? _____

Describe your relationship with God: _____

What do you consider the role of God in your recovery? _____

Describe your level of comfort with the inclusion of such things as prayer and scripture in your counseling sessions: _____

Miscellaneous:

Is there anything else that it would be helpful for me to know about you? _____

Goals and Objectives:

What would you like to gain from your counseling experience? What would you like to be different when you are finished with your treatment? Please be as detailed as possible. You may continue on the back if necessary.

1. _____

2. _____

3. _____

Thank you so much for taking the time to fill out this lengthy questionnaire. It can be difficult to be vulnerable with the details of your life, but I promise that the time you took to fill this out will be extremely helpful in assisting me in our work together. I look forward to working with you!

Signature: _____ Date: _____

Counselor: _____ Date: _____

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