Amanda DePippo, LMHC, CAP

PSYCHOSOCIAL ASSESSMENT

Name: ____________________________

Age: ________ Sex: ______

DIRECTIONS: Please answer the following questions as fully as possible.

Present Problem/Stressors: *Please check all that apply:*

❒Marital issues ❒Health issues ❒Job issues ❒Financial issues
❒Parent/child issues ❒Issues of past (guilt, abuse, neglect, family of origin issues, etc.)
❒Other ____

Symptoms: *Please check all that apply:*

❒ Change in sleep pattern ❒ Depressed mood ❒ Mood swings
❒ Decreased energy ❒ Decreased interest or pleasure ❒ Anger problems
❒ Decreased concentration ❒ Change in appetite ❒ Thoughts of death
❒ Decreased motivation ❒ Anxiety/Worry/Panic ❒ Suicidal/Homicidal Ideation
❒Other ____

What has prompted you to seek counseling? ____
____
____

Describe additional problems you are experiencing. ____
____
____
____

When did these problems develop? ____
____

Check any recent losses you have experienced.

❒ Family ❒ Health ❒ Disruption of lifestyle ❒ Job ❒ Significant other

❒ Other ____

____

____

____

____

Psychiatric History

Have you ever had any previous outpatient counseling? ❒ yes ❒ no
If yes, please complete information below.

Place	Length of Time	Date(s)

Have you ever been admitted to the hospital for mental health or addiction issues? ❒ yes ❒ no
Place: ____ Dates: __________________________________
Name of current doctor and/or therapist: ____
Have you ever received a psychiatric diagnosis? ❒ yes ❒ no If yes, please explain. ______________
____

Do you feel medications you have been on, past or present, have been effective? ❒ yes ❒ no
Please explain: ____
List all medications you have taken *in the past* for anxiety, depression, and/or sleep. ________________
____
____

Medical Information

How would you describe your current condition of health? _____________________________________
Do you have any disabilities and/or disorders? ❒ yes ❒ no If yes, explain. ______________________
____
Explain any special adjustments needed for the disability or disorder: ____________________________
____

Are you currently on any medication? ❒ yes ❒ no If yes, please complete the information below.

Name of medication	Dosage/Frequesncy	Prescribing Physician

List any previous health problems, operative procedures, and medical hospitalizations.

Problem	Date	Treatment

Substance Use History

Describe your current usage, or usage within the past year (*includes alcohol, any illegal drugs, caffeine and tobacco*).

Family alcohol/drub abuse history:

- ❒ Father
- ❒ Mother
- ❒ Grandparent (s)
- ❒ Sibling (s)
- ❒ Other ________________________
- ❒ Stepparent/live-in
- ❒ Uncle (s) / Aunt (s)
- ❒ Spouse/Significant other
- ❒ Children

Treatment History:

- ❒ Outpatient (ages) _____________________
- ❒ Inpatient (ages) ______________________
- ❒ 12-Step Program (ages) ________________
- ❒ Stop on own (ages) ___________________________
- ❒ Other (ages) _________________________________
  Describe:___________________________________

Substance use: ***(Complete all that apply)***

			CURRENT USE		
	First use Age	**Last use Age**	**(Yes/No)**	**Frequency**	**Amount**
❒ Alcohol	__________	__________	______	________	______
❒ Amphetamines/Speed	__________	__________	______	________	______
❒ Anti-Anxiety	__________	__________	______	________	______
❒ Barbiturates/Sedatives	__________	__________	______	________	______
❒ Caffeine	__________	__________	______	________	______
❒ Cocaine	__________	__________	______	________	______
❒ Crack Cocaine	__________	__________	______	________	______
❒ Hallucinogens (e.g., LSD)	__________	__________	______	________	______
❒ Heroin	__________	__________	______	________	______
❒ Inhalants (e.g., glue, gas)	__________	__________	______	________	______
❒ Marijuana or Hashish	__________	__________	______	________	______
❒ Methadone	__________	__________	______	________	______
❒ Nicotine/Cigarettes	__________	__________	______	________	______
❒ PCP	__________	__________	______	________	______
❒ Prescription __________________________	__________	__________	______	________	______
❒ Sleeping Pills	__________	__________	______	________	______
❒ More than 1 substance __________________	__________	__________	______	________	______

Issues Related to Substance Use: ***(Check all that apply)***

- ❒ Arrests
- ❒ Assaults
- ❒ Binges
- ❒ Blackouts
- ❒ Hangovers
- ❒ Job Loss
- ❒ Loss of control amount used
- ❒ Medical Conditions
- ❒ Overdose
- ❒ Other ____
- ❒ Relationship Conflicts
- ❒ Seizures
- ❒ Sleep Disturbance
- ❒ Suicidal Impulse
- ❒ Tolerance Changes
- ❒ Withdrawal Symptoms

Nutrition

Do you feel you have balanced, healthy eating patterns? ❐ yes ❐ no
Do you have a lot of concerns about your weight and shape? ❐ yes ❐ no
Do you often eat out of depression, boredom, anger? ❐ yes ❐ no
Do you ever binge eat or fear losing control of your eating? ❐ yes ❐ no
Do you ever self-induce vomiting? ❐ yes ❐ no

How do you feel about eating with others in a group? ____

Do you use laxatives, diuretics (water pills), or diet medications to control your weight? ❐ yes ❐ no
Do you or others believe you exercise excessively? ❐ yes ❐ no

Legal History *Please explain all that apply.*

Charges as a minor: ____
Charges presently: ____
Arrests (How many): ____

Developmental History

List members of your family of origin and comment on how you get along with each one.

Name	Relationship	Comment

What was your birth order? I was the _____ of _____ children. Who primarily raised you? ___________
How would you describe your childhood? ❐Traumatic ❐ Painful ❐ Uneventful ❐ Good ❐ Happy
What were you like as a child (include friends, school, hobbies, and personality)? ___________________
____
____
____

Did you have any unusual or traumatic experiences as a child?

Date	Age	Event

Have you ever been the recipient of unwanted sexual acts? ❐ yes ❐ no
If yes, please explain: ____
Have you ever been the victim of abuse, neglect, or violence? ❐ yes ❐ no
If yes, please explain: ____

Have you ever been the perpetrator of abuse, neglect, or violence towards another person? ❐ yes❐ no
If yes, please explain: ____
____
____

Living Arrangements

❐ Satisfactory? ❐ Unsatisfactory?
Where do you currently live? ______________________________ How long there? ______
With whom are you living? ____
Describe your current relationships with family members. ______________________________
____
____
____

Social Relationships/Support System

Who can you count on for support? *Check as many as apply.*
❐Parents ❐Spouse ❐Siblings ❐Extended Family ❐Employer ❐Church
❐Pastor ❐Co-worker ❐Neighbor(s) ❐Close Friend ❐Self-help Group
❐Community Services ❐Therapist ❐Medical Doctor

What are your hobbies or leisure activities? ____________________________________

Marital History *(if applicable)*

When were you married? _______________ Name and age of spouse. ______________________
Previous marriage(s)? ❐ yes ❐ no If yes, date of divorce(s). ___________________________
How many children from above marriage(s)? ______________________________________
What is your perception of your current marriage (include communication patterns, problems, sexual relations). ____
____
____
____
List names and ages of children. How do you get along with each one?

Name	Age	Comment

Religious/Cultural Factors

What is your religious background? ____

Do you currently attend church, synagogue, mosque, or other religious services? ❒ yes ❒ no

What do you consider to be the role of God in your recovery? _________________________________
____
____
____

Please list any issues (*positive or negative*) which are important or may have affected you in regard to religion or ethnic/cultural background. ____
____
____
____

What was school like for you? ____
____

Highest grade level achieved. ____________ What type of grades did you make? _________________
Are you currently in school? ❒ yes no If yes, what grade level? ______________________________

Work Adjustment History

Describe your current job/career. ____
____

Military History

List branch, dates, and duties.
____
____

Miscellaneous

What would you like to accomplish during your treatment with *Amanda DePippo, LMHC, CAP?*

____

____

____

____

____

Client Name: *(Print)* ______________________________________ **Date:** ___________________

Client Signature: ____ **Date:** ____________________

Read and Reviewed by ____________________________________ **Date:** ____________________