**Psychosocial Assessment**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by:

Client: Client’s DOB:

**Reason for coming in:**

**Personal and Family History:**

Raised by: □ biological parent(s) □ adoptive parent(s) □ grandparent(s) □ other:

Siblings: Name DOB Describe Relationship

Sexual Orientation: □ heterosexual □ Gay or Lesbian □Bisexual □ Transgender □ Questioning/Queer

Relational Status: □ single □ living together/married/partnered □ separated/divorced □ widowed

Children: Name DOB Describe Relationship

**History of physical, sexual or emotional abuse:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other relevant family factors:

**Social, Cultural and Religious Factors:** include significant friendships & community involvement.

**Education, Employment and/or Military Service History:**

Highest level of education: □ elementary □ middle school □ high school □ college □ graduate

Learning Disabilities YES/NO / ADHD YES/NO

**Medical History:**

General Health: □ excellent □ good □ fair □ poor

Please list any surgeries & Dates, or current medical conditions below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Hospitalization(s): Psychiatric**

Dates from-to Reason Outcome

**Relevant Family Medical History**:

1. Mother- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Father-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Smoke: NO/YES cigarettes/day \_\_\_\_\_\_\_

Drink? NO/YES Dailey (how many)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occasionally (how many): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Use: NO/YES**

Marijuana: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Opioids: (drug name /how much) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Drug Use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal History:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Mini Mental Status Exam:**Oriented to: □ person □ place □ time □ situationMood: Affect: Dress & Grooming: Speech & Cognition: Sui Ideation: YES NO Homi Ideation: YES NOIf yes to either of above, describe any early interventions:Substance Abuse Issues:**ICD 10- Diagnostic Codes:**Axis I:Axis II:Axis III:Axis IV:Axis V: Current GAF: **Goals for Therapy:** 1.
2.
3.

4. |