Connection Counseling
SERVICES
Reconnecting Lives, Restoring Futures

Psychosocial Assessment Form

Client's Name: _____

Instructions: Please fill in all blanks with detailed information or put N/A if it does not apply. ***(To be completed by the client or responsible individual)***

I. Presenting Program

What are the primary problems/ circumstances you have been experiencing which led to your need for Counseling Services?

_____

_____

Place a check next to your presenting/current symptoms:

___Increased Anxiety	___ Depressed Mood	___Low Energy Level
___ Racing thoughts	___Poor concentration	___Indecisiveness
___Sleep disturbance	___Appetite disturbance	___Angry outbursts
___Crying Spells	___Lack of motivation	___Recent Weight Change
___Excessive Guilt	___Isolating from others	___feelings of hopelessness
___Low self-worth	___Mood Swings	___Difficulty with memory
___Paranoia	___Thoughts / Intentions/ Plans of hurting yourself	
___Inability to stop using drugs / chemical		___Inability to stop using alcohol

Christopher Merrell, Ed.D., LPC Phone: 469-337-1160/ Fax: 972-218-7754
1106 Sante Fe Trail, Suite 3, Duncanville, Texas 75137

II. Current Situation

A. Family Structure / Living Situation

Describe your current living situation:

_____
_____

B. Occupational Status:

Where are you currently employed? _____
Position / Job Title_____
Duration of employment? _____ Income_____
Military Service Yes/No? If yes, which Branch of Service and Time of Service:
_____

C. Religious Affiliation and History

Identify involvement in religious activities or spiritual organizations.

_____
_____
_____

III. Social Background (Individual and Family History)

A. General Information

Ethnicity/Location Born and Raised:_____

Identify the socioeconomic status of your family of origin.

___Lower Class __Middle Class __Upper – Middle Class ___Upper Class

B. Parents

Identify your father's name, age, location, and occupation.

_____
_____

Describe the history of your relationship with your father.

_____
_____

Identify your mother's name, age, location, and occupation.

Describe the history of your relationship with your mother.

Briefly describe your parents' marital history.

D. Siblings (Brothers and Sisters)

E. Family Health/Illness

Identify the history of physical illnesses / injuries to your family of origin and current family.

Identify the history of psychiatric / emotional / drug / alcohol / problems and treatment in your family of origin and current family.

IV. Individual History as Related to the Client

B. Developmental History

Describe any emotional, mental or physical problems you had during your childhood or adolescence.

_____
_____

B. Educational History

Where and when did you graduate from high school or attain an equivalent diploma?

_____

Identify any continuing education or College hours/degrees you completed after high school? Please provide specifics date, year, hours, etc.

_____
_____

Identify any History of learning difficulties?

_____
_____

C. Marital History

Current Marriage
Name of Spouse: _____ Age: _____ Year of Marriage: _____

Names and ages of children (If applicable):

_____
_____

Previous Marriage
Name of Spouse: _____

Year of Marriage: _____Year of divorce: _____
Reason(s) for divorce:

_____

Names and ages of children (If applicable):

_____
_____

D. Medical History

Identify your history of any previous psychiatric/ drug and alcohol treatment or counseling. Be specific.

_____
_____

Identify current Medications (Type, Quantity, dates)

Identify your history of serious illnesses or injuries.

History of any eating disorders? Yes, or no? If yes, please provide details.

Describe any situations in which you were ever sexually abused or abusive. Identify your age at the time of the offense and the age of the abuser (N/A – it does not apply).

Describe any sexual or intimacy problems you are currently experiencing (optional).

G. <u>Substance/Alcohol Use History</u>

How old were you when you were introduced to the use of: Alcohol _____ Drugs ____

Describe your alcohol/ drug use (all drugs) on the chart below.

Substance	Age Started	Age Stopped	Ongoing use?	Identify Quantity and Frequency	Method of use (IV, Oral, Etc…)	When was the last time you used?
Marijuana						
Heroin						
Cocaine/Crack						
Alcohol						
Cigarettes						
Other Drugs (Specify)						
Other Drugs (Specify)						

G. <u>Alcohol/ Substance Use History (cont'd)</u>

Put a check next to those that apply:

___ I have a drinking problem ___ I have a drug problem

___My goal is to quit alcohol / drugs ___ My goal is to control / reduce usage Use.

When and where are you most likely to use or drink (High Risk Situations):

_____

_____

Identify the effects of your drug / alcohol use on your financial stability.

_____

_____

List Symptoms / Consequences of using (check all that apply):

___Drinking / Using ___Convulsions___ Drinking / Using Less
___Nausea / Vomiting/ Upset Stomach

___Daily use for 2 or more weeks___ Sweating ___Loss of control ___Muscle Cramps

___Withdrawal symptoms/ tremors/ shakes ___DT's ___Morning drinks/ using

___Liver problems ___Blackouts / memory loss ___Diabetes

___Needed it or depended on it ___Overdose ___Hallucinations (seeing or hearing things)

___Passing out/ fainting ___Emotional / psychiatric problems ___Physical/ Health problems

Do you have a history gambling problem? (If so, specify kind of gambling, frequency, and money involved)

_____

_____

_____

H. <u>Legal History</u>

Have you ever been arrested? Yes or no ____When (month, year)?
_____ Offense(s)? _____
Outcome (imprisonment, probation, etc.)? _____
Any pending legal issues? ____Yes ____No
If yes, explain? _____

Name and address of probation or parole officer. _____

_____

_____