Adult Psychosocial History and Intake Assessment

Date:_____/_____/___ PCP _____ Referral __ _____

Client Legal Name: _____ Nick Name: _____ Age: ___ Gender: ___ Race: _____

Emergency Contact (sign release):_____

Why are you seeking treatment?

_____

What do you hope we can do for you?

_____

What do others want you to change?

_____

List present stresses:_____

<u>Social History</u>

Are you married? _____ Divorced?_____ Single? _____

Any conflicts? _____ Present living arrangements _____

Current Household	Dynamics	Age	Relationship
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

Childhood Household	Dynamics	Age	Relationship
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

Social interactions with peers, siblings, parents, grandparents and others:_____

What do you like most about yourself?_____

What do you dislike most about yourself?_____

Are you happy in your vocation? (Explain) _____

Are you unhappy in your vocation? (Explain) _____

Military? (Explain) _____

Habits: Alcohol current _____ past _____ Drugs current _____Past_____
Smoke packs daily _____ How long _____ Diet _____Exercise _____

Education: ☐ High School ☐ College ☐ Graduate School ☐ Other Training ☐ Learning Disabilities

☐ Other:_____Explain: _____

What are your hobbies, interests, socialization activities, etc.

_____

Spiritual Beliefs: _____

Psychiatric History:

Date	Type of care			Where/who provided these services	Reason you sought services
	Out patient	In patient			

Is there any family history for ☐ Anxiety☐ ADHD ☐ Bipolar ☐ Depression ☐ Schizophrenia ☐ Alcoholism ☐ Drug abuse
Explain: _____

_____

Medical History:

☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Seizures ☐ Medical Hospitalization ☐ Surgeries

☐ Other: _____

Present Medications/Dose/Effectiveness/Side Effects (including over the counter medications)

1._____ _____ _____ _____

2._____ _____ _____ _____

3._____ _____ _____ _____

Past Medications/Dose/Effectiveness/Side Effects (including over the counter medications)

1._____ _____ _____ _____

2._____ _____ _____ _____

3._____ _____ _____ _____

Allergies to animals, foods, etc _____

Allergies to medications _____

Wish to become pregnant? _____**Birth Control?**_____ **Last Period?**_____

Describe any sleep difficulties (falling asleep, staying asleep) _____

Trauma History

Is there now or in your childhood any abuse to include ☐ neglect ☐ physical ☐ sexual
Explain: _____

_____

Any other traumas (motor vehicle accident, witness/victim of crime, witness of domestic violence, victim of bullying, etc.)
Explain: _____

_____

Any substance abuse/frequency/duration:

_____

Any financial issues _____

Any current or past court issues_____

Any sexual difficulties or issues you or others are concerned about _____

Explain:_____