The Power in Parenting

Changing Generations – One Family at a Time

Assessment/Evaluation/PsySoc History Form (Ages 18 & Older)

Please take your time and fill out the entire form. Information you give us will help your therapist understand you better. You may use the backside if needed. Thank you.

Your Name: _____Age:_____ Date_____

	Full Name	Age	Living with You	If Deceased, Year & Cause
Father:				
Mother:				
Spouse/Partner				
Child: 1				
Child: 2				
Child: 3				
Child: 4				
Child: 5				
Who else lives with you other than the ones checked above?				

Current Marital Status	Months / Years	Current Marital Status	Months / Years
Unmarried		Separated	
Living Together		Divorced	
Married		Widowed	

Who were you raised by: _____ Were you adopted: _____

Age first married: ___ Number of times married: ___ or lived with partner: ___Number of times divorced: ___

Number of Brothers living: ___ Deceased: ___ Sisters living: ___ Deceased: ___ How many are older than you: ___

Which family members are you close to now: _____

What recently happened to make you decide to seek help now: _____

_____

_____

What would you like this counselor to do for you:

_____

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EDUCATION:

Last grade completed: _____ Degree: _____ In School Now: ☐ Yes ☐ No

Special Training or skills: _____

Hope or Plan to go to school: _____

Do you have a learning disability: ☐ Yes ☐ No If Yes, explain: _____

_____

PHYSICAL HEALTH: Check all items that apply to you now or in the past:

☐ Allergies	☐ Hypoglycemia (low blood sugar)	☐ Low Blood Pressure	☐ Asthma	☐ Diabetes
☐ Head Injury	☐ Hypertension (high BP)	☐ Stomach problems	☐ AIDS	☐ STDs
☐ Pancreatitis	☐ Bacterial endocarditis	☐ Severe headache/migraine		☐ Lupus
☐ Liver Disease	☐ Prolapsed mitral valve	☐ Chronic Pain	☐ Hepatitis	☐ Insomnia
☐ Circulation Problems	☐ Injury from abuse	☐ Thyroid Problems	☐ Large Weight Gain	☐ Impotence
☐ Chronic Fatigue	☐ Large Weight loss	☐ High Cholesterol	☐ Appetite disturbance	☐ Ulcers
☐ Vision Problems	☐ Irritable Bowel	☐ Speech Problems	☐ HIV Positive	☐ Seizures
☐ Back Problems	☐ Hearing Problems	☐ Heart Disease	☐ Major Surgery	☐ Cancer

☐ Major Accidents: _____

Primary Physician's Name: _____

Physician's Address: _____Phone: _____

Date of your last physical: _____ Results: _____

List all medications you are on for medical reasons:

_____

Do you skip meals often: ☐ Yes ☐ No Eat a well-balanced diet: ☐ Yes ☐ No

Do you eat much junk food: ☐ Yes ☐ No Do you exercise regularly: ☐ Yes ☐ No

FOR WOMEN:

Number of pregnancies: _____ Live births: _____ Miscarriages: _____ Stillbirths: _____ Abortions: _____

Do you have normal menstrual cycles: ☐ Yes ☐ No Normal menstrual flow: ☐ Yes ☐ No

Are you pregnant: ☐ Yes ☐ No Premenstrual Syndrome: ☐ Yes ☐ No Menopause: ☐ Yes ☐ No

INTEREST ACTIVITIES: (What do you enjoy doing)

☐ Television	☐ Be with friends	☐ Shop	☐ Movies/Video	☐ Fix/Repair things
☐ Be with family	☐ Go to School	☐ Sew/Knit/Crochet	☐ Video Games	☐ Play Instrument
☐ Be alone	☐ Study	☐ Build/Decorate	☐ Music Listening	☐ Go to Museum
☐ Cook	☐ Get High	☐ Gardening	☐ Eat	☐ Sex
☐ Exercise	☐ Photography	☐ Sing	☐ Play Sports	☐ Roller-blade/skate
☐Care for Elderly/Ill	☐ Dance	☐ Volunteer work	☐ Watch sports	☐ Church Activities
☐ Child-care	☐ Read	☐ Travel/Site-see	☐ Hike	☐ Draw
☐ Play Cards	☐Write	☐ Pray/Read Bible	☐ Gamble	☐ Other: _____

Have you recently lost interest in activities you normally enjoyed: ☐ Yes ☐ No

EMPLOYMENT:

What do you do for a living: _____

Current employer: _____ Title: _____ Years on the job: _____

Pay rate: _____ Have you ever been fired from a job: ☐ Yes ☐ No If yes, how many times: _____

Reasons: _____

Do you have any problems on current job: ☐ Yes ☐ No If yes, explain: _____

_____

FINANICAL:

Do you have any financial problems: ☐ Yes ☐ No If yes, explain: _____

What types of financial aid do you receive: _____ Monthly amount: _____

What types of aid do other household members receive: _____ Monthly amount: _____

LEGAL HISTORY:

Arrest Date	Charge	Convicted	Sentence

Are you currently on Probation: ☐ Yes ☐ No Parole: ☐ Yes ☐ No Ending Date: _____

Are you involved in any lawsuits: ☐ Yes ☐ No If yes, explain: _____

Do you have any upcoming Court Dates: ☐ Yes ☐ No If yes, explain: _____

MILITARY SERVICE:

Type: _____ When: _____

Type of Discharge (Explain if Dishonorable): _____

Describe any combat experience: _____

Are you troubled now by your military experience: ☐ Yes ☐ No If Yes, explain: _____

_____

ETHNIC/CULTURAL BACKGROUND:

Do you have any ethnic or cultural concerns: ☐ Yes ☐ No If Yes, explain: _____

_____

RELIGIOUS/SPIRITUAL BACKGROUND:

Current religious/spiritual involvement/activities:

Do you have any religious or spiritual concerns: ☐ Yes ☐ No If Yes, explain: _____

_____

SEXUAL/GENDER ISSUES:

Do you have any sexual or gender concerns: ☐ Yes ☐ No If yes, describe your concerns: _____

SYMPTOMS:

Current Presenting Problem(s) Onset: _____

_____

_____

Background History of Presenting Problem: _____

_____

_____

MENTAL/BEHAVIORAL STATUS

Orientation: ☐ Normal Disoriented as to: ☐ Time ☐ Place ☐ Person

Psychomotor Activity: ☐ Normal ☐ Accelerated ☐ Retarded ☐ Restless/Fidgety ☐ Agitated

Mood: ☐ Normal ☐ Depressed ☐ Elevated ☐ Anxious ☐ Other: _____

Affect: ☐ Congruent w/mood and thought ☐ Incongruent w/mood and thought
☐ Inappropriate ☐ Intense ☐ Shallow ☐ Flat ☐ Labile
☐ Detached ☐ Controlled ☐ Sad ☐ Tearful ☐ Hopeless ☐ Anxious
☐ Fearful ☐ Embarrassed/Shameful ☐ Euphoric ☐ Angry/Irritable
☐ Evidence of Dissociation ☐ Other: _____

Insight/Psychological Mindedness: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Judgment: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Impulse Control: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Behavioral Attitude: ☐ Cooperative ☐ Passive/compliant ☐ Withdrawn ☐ Guarded
☐ Resistant ☐ Hostile ☐ Other: _____

Attention and Concentration: ☐ Good ☐ Fair ☐ Distractible ☐ Other: _____

Flow of Cognitive Associations: ☐ Intact ☐ Loose/Disjointed ☐ Tangential ☐ Accelerated ☐ Slowed

Thought Process: ☐ Normal ☐ Obsessive ☐ Grandiose ☐ Paranoid ☐ Thought Disordered
☐ Delusional ☐ Evidence of Hallucinations ☐ Feeling Talked About
☐ Unusual Thoughts ☐ Other: _____

PLEASE CIRCLE ALL THAT APPLY:

	Past		**Present**	
Suicidal:	ideations/attempts/NA		ideations/attempts /NA	
Homicidal:	ideations/behavior/NA	victim/perpetrator	ideations/behavior/NA	victim/perpetrator
Domestic Violence:	yes/no	victim/perpetrator	yes/no	victim/perpetrator
Workplace Violence:	yes/no	victim/perpetrator	yes/no	victim/perpetrator

EATING AND BODY IMAGE RELATED BEHAVIOR:

☐ Normal ☐ Negative body image ☐ Distorted body image _____

Restrictive eating: ☐ Mild ☐ Moderate ☐ Severe

☐ Generalized excessive eating ☐ Intermittent binge eating ☐ Frequent binge eating ☐ Purging

☐ Vomiting ☐ Laxatives ☐ Exercise diet pills ☐ Diuretics ☐ Other: _____

Details (frequency, body weight, physical symptoms, etc.): _____

_____

DEPRESSIVE/BIPOLAR MOOD AND AFFECT ISSUES:

☐ None ☐ Dysphoria ☐ Crying episodes ☐ Hopeless/helplessness ☐ Suicidal Ideation
☐ Euphoria ☐ Rapid/pressured speech ☐ Loneliness ☐ Emptiness
Onset _____ Frequency _____ Duration _____

PERCEPTION OF SELF:

☐ Normal ☐ Low self-esteem ☐ Self-criticism/guilt/shame ☐ Grandiose

ENERGY:

☐ Normal ☐ Low energy/fatigue ☐ Elevated energy ☐ Agitated energy ☐ Restlessness

MOTIVATION AND ENGAGEMENT:

☐ Normal ☐ Low motivation ☐ Falling behind w/academics ☐ Procrastination
☐ Decline in self-care ☐ Interpersonal withdrawal and isolation ☐ Impulsivity
☐ Sometimes not attending class ☐ Frequently not attending class ☐ Has stopped attending class
☐ Increased/excessive goal-directedness ☐ Excessive involvement in pleasurable/dangerous activities

SLEEP:

☐ Normal ☐ Difficulty falling asleep ☐ Difficulty sustaining sleep ☐ Early morning awakening
☐ Excessive sleep ☐ Daytime napping ☐ Decreased need for sleep ☐ Delayed sleep cycle
☐ Nightmares
Typical time asleep: _____ Typical time awake: _____ Recent changes _____

SEXUALITY/SEXUAL ORIENTATION ISSUES:

☐ Normal ☐ Depressed libido ☐ Elevated libido ☐ Addiction/compulsivity ☐ Conflicted about sexual issues

ATTENTION / CONCENTRATION:

☐ Normal ☐ Generalized difficulties with attention and concentration ☐ Academic/learning related difficulties
☐ Easily distractible ☐ Difficulty sustaining mental effort ☐ Difficulties with planning and organization
☐ Frequently losing or misplacing things ☐ Frequent forgetfulness ☐ Frequent indecisiveness

ANGER:

☐ None ☐ Yelling ☐ Push/Hit/Choke Someone ☐ Throwing/Breaking things/Punching Walls
☐ Difficulties keeping relationships due to anger ☐ Difficulties keeping a job due to anger
☐ Increased Anger when under stress ☐ Known/Unknown anger triggers
☐ Is your partner sometimes afraid of you ☐ Are your children afraid of you sometimes

ANXIETY:

☐ Normal ☐ Generalized excessive worry ☐ Difficulty relaxing ☐ Worries/anxieties over specific issues:
_____
_____
☐ Financial worries ☐ Fear of Dying ☐ Obsessive Thoughts: _____
_____
_____

☐ Panic ☐ Rapid heart rate ☐ Rapid breath/hyperventilation ☐ Dizziness/feeling faint
☐ Sweating ☐ Chest pain ☐ Trembling/shaking ☐ Nausea/abdominal distress
☐ Feeling overwhelmed/terrified ☐ Other symptoms: _____

Onset _____ Frequency _____ Duration _____

☐ Social discomfort ☐ Generally shy ☐ Social avoidance ☐ Discomfort with large groups
☐ Discomfort with opposite sex ☐ Extreme discomfort with public speaking/class presentations

TRAUMA/DISSOCIATIONS:

☐ None ☐ Intrusive thoughts/images ☐ Flashbacks/reliving of trauma
☐ Physiologic hyper-activity ☐ Affective numbing ☐ Avoidance of trauma-related stimuli
☐ Trauma-related nightmares ☐ Hyper vigilance ☐ De-realization/depersonalization
☐ Dissociative episodes
When? _____

SUBSTANCE USE ISSUES:

	Past	Occasional	Problematic	**Present**	Occasional	Problematic
Alcohol:	☐	☐	☐	☐	☐	☐
Nicotine:	☐	☐	☐	☐	☐	☐
Cannabis:	☐	☐	☐	☐	☐	☐
Cocaine/Crack:	☐	☐	☐	☐	☐	☐
Heroine/Methadone:	☐	☐	☐	☐	☐	☐
Amphetamines:	☐	☐	☐	☐	☐	☐
Pain Killers:	☐	☐	☐	☐	☐	☐
Prescription Meds:	☐	☐	☐	☐	☐	☐
Inhalants:	☐	☐	☐	☐	☐	☐
Steroids:	☐	☐	☐	☐	☐	☐

☐ Client acknowledging substance use difficulties ☐ Client minimizing substance use difficulties

Onset _____ Frequency _____ Duration _____

Has your drinking or drug usage ever caused you problems in any of the following areas:
☐ Family ☐ Employment ☐ Legal ☐ Emotional ☐ Social ☐ Financial ☐ Behavior ☐ Physical/Medical

Does a relative, loved one, friend, court or employer feel you have an alcohol or drug problem: ☐ Yes ☐ No

PREVIOUS MENTAL HEALTH OR ALCOHOL/SUBSTANCE ABUSE TREATMENT:

Outpatient: Have you seen a therapist /counselor for personal or family problems or alcohol/drug treatment:
☐ Yes ☐ No If yes, when and where: _____
Reason: _____
Any involvement in self-help support groups such as AA, NA, ACOA, CODA, RR, EA, AIM, ISA, Recovery: ☐ Yes ☐ No
If yes, when and where: _____
Reason: _____

Inpatient: Have you been in a hospital or residential treatment for personal problems or alcohol/drug problems:
☐ Yes ☐ No If yes, when and where: _____
Reason: _____
Were any of your treatment experiences helpful? ☐ Yes ☐ No If yes, explain: _____
_____
What medications were you prescribed: _____
Which of those medications were helpful: _____
Have any family members been hospitalized for personal or substance abuse problems: ☐ Yes ☐ No
If yes, who, when, where: _____

CHILDHOOD EXPERIENCES:

A) List the negative characteristics of your parents:

_____

_____

_____

_____

_____

B) List the positive characteristics of your parents:

_____

_____

_____

_____

_____

C) List how you felt when you think of your positive childhood experiences:

_____

_____

_____

_____

_____

D) List how you survived and coped with your negative childhood experiences:

_____

_____

_____

_____

_____

Below - For Therapist Only

Axis I: 1) _____ 3) _____

2) _____ 4) _____

Axis II:

_____

Axis III:

_____

Axis IV Psychosocial/Environmental Factors:

_____

_____

Axis V (GAF): |_____|_____|

0 10 20 30 40 50 60 70 80 90 100

Comments:

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Therapist Signature Credentials Date