LIST PSYCHOLOGICAL SERVICES, PLC
ADULT PSYCHOSOCIAL ASSESSMENT

CA BC Wilder LPR SAG Center BC Washington Huron

GENERAL INFORMATION:

Date: _____ **Client Name**:_____ Gender: ☐ M ☐ F
Age:_____ Birth Date:_____ With whom do you live?_____

Why are you seeking services at this time:_____
_____

FAMILY HISTORY:

- Who were you raised by (check all that apply): ☐ Biological mother ☐ Biological father ☐ Stepmother ☐ Stepfather ☐ Other: _____
- How many brothers and sisters do you have? _____
- Is there a history of mental illness in the family? ☐ Yes ☐ No If yes, who and what kind of problems?_____
  _____
- Have any family members committed suicide? ☐ No ☐ Yes, Who?_____
- Is there a history of drug and/or alcohol problems in the family? ☐ No ☐ Yes, who and what kind of substance?
  _____
- Please describe the family in which you were raised._____
  _____

Have you experienced any of the following as a child (please check all that apply):

___ Physical abuse
___ Neglectful home environment
___ Emotional abuse
___ Exposure to domestic violence
___ Exposure to other chronic violence
___ Sexual abuse or exposure
___ Parental substance abuse
___ Impaired parenting (mental illness)
___ Exposure to drug activity aside from parental use
___ Refugee camps, ware zones, trafficking (including forced prostitution)
___ Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy
___ Lengthy or multiple separations from primary attachments – parent, other caregivers, siblings or close friends
___ Placement outside of the home (foster care, kinship care, residential)
___ Loss of significant people, places etc.
___ Frequent/multiple moves; homelessness
___ International adoption, immigration,
___ Other _____

Have you experienced any of the following as an adult (please check all that apply):

___ Domestic violence/assault (DV)
___ Physical abuse/assault other than DV
___ Emotional abuse by partner
___Trafficking and/prostitution
___Sexual assault (not included above)
___Refugee camps, war zones
___ Incarceration/institutionalization
___ Military trauma
___ Loss of significant people, places etc.
___ Frequent/multiple moves; homelessness
___ Other _____

CULTURAL:

- Do you identify with a particular ethnic group? ☐Yes ☐ No If yes, please name:_____
- Do you identify with a particular religious group? ☐Yes ☐ No If yes, which one:_____
- Have you experienced any difficulties related to your culture, ethnicity or religious affiliation? ☐ Yes ☐ No
  If yes, please explain:_____

MARRIAGE AND PARTNERSHIP:

- Present relationship status: ☐ Never married ☐ Married/living together ☐ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐ Boyfriend ☐ Girlfriend ☐ No Significant Relationship
- If married/cohabitating, how many years with current partner? _____
- Are you currently or have you experienced any physical, emotional, or sexual abuse in your relationship(s)? If yes, please explain. _____
  _____
- Has your significant other ever struggled or currently struggles with an emotional condition? ☐ Yes ☐ No
- Has your significant other ever struggled or currently struggles with a drug or alcohol problem? ☐ Yes ☐ No
- How many children do you have? _____ What are their ages?_____
- Previous relationships/marriages:
  Dates:_____ Description:_____ Number of Children:_____
  Dates:_____ Description:_____ Number of Children:_____
  Dates:_____ Description:_____ Number of Children:_____

EDUCATION/EMPLOYMENT HISTORY:

- What is the highest level of education you received?_____
- Do you have any learning problems?_____
- Did you have any bullying issues while in school?_____
  _____
- Are you currently employed? ☐ Yes ☐ No What is your occupation?_____
- Do you have any other sources of income? If Yes, please list.☐ Yes ☐ No_____
- Do you have any current employment issues? ☐ Yes ☐ No _____
  _____

MEDICAL HISTORY:

- Medical Primary Care Physician: _____ Date last seen: _____
- Have you had a physical in the last 2 years (one year if over 40)?_____ If yes, when?_____
- How do you rate your general health? ☐ poor ☐ fair ☐ average ☐ good ☐ excellent
- What, if any, medical problems do you have (such as seizures, diabetes, heart or thyroid issues)?_____
  _____
- Are you currently taking medications? ☐ Yes ☐ No If yes, what medications?_____
  _____
  _____
- Drug allergies/adverse reactions/side effects_____
  _____
  _____
- Do you have any concerns related to your weight?_____
- Has your weight change over the last year? ☐ No ☐ Yes ☐ Lost _____lbs. ☐ Gained _____lbs.
- Do you have any changes in eating habits/appetite? ☐ Yes ☐ No If yes, please describe: _____
  _____
- Do you currently participate in any type of exercise/physical activity? If yes, please describe: _____
  _____
  _____
- Caffeine Use: How many cups, cans or glasses of caffeinated beverages per day do you drink? _____
- Do you currently use any tobacco products? If yes, describe_____
- Have you had any head injuries or loss of consciousness? ☐ Yes ☐ No If yes, explain:_____
  _____
- Have you had any surgeries? ☐ Yes ☐ No If yes, please list dates and what type:_____
  _____
- Do you or have you ever struggled with eating issues such as binging, purging, compulsive overeating or going days without eating? If yes, please describe._____
  _____

PSYCHIATRIC HISTORY:

- Have you been in counseling before? ☐ Yes ☐ No If yes, what type and when:_____
  _____
  _____
- Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No If yes, where and when:_____
  _____
  _____
- Listed below are a number of categories in which people commonly find some difficulties. Please indicate how you are affected in each area by circling the appropriate number (please circle only one number for each item).

NO PROBLEM #1	SOMEWHAT OF A PROBLEM #2	MODERATE PROBLEM #3	SERIOUS PROBLEM #4	SEVERE PROBLEM #5

Depression	1 2 3 4 5	Sudden Change in mood	1 2 3 4 5
Anxiety	1 2 3 4 5	Lack of energy	1 2 3 4 5
Anger control problems	1 2 3 4 5	Not liking self	1 2 3 4 5
Hallucinations (hearing voices or seeing things)	1 2 3 4 5	Not liking others	1 2 3 4 5
		Withdrawal from others	1 2 3 4 5
Thoughts of homicide	1 2 3 4 5	*Problems with Sleep	1 2 3 4 5
Thoughts of suicide	1 2 3 4 5	Nightmares	1 2 3 4 5
*Suicide attempts	1 2 3 4 5	Overly suspicious	1 2 3 4 5
*Obsessions or compulsions	1 2 3 4 5	Problems with spouse	1 2 3 4 5
*Serious trauma	1 2 3 4 5	Problems with children	1 2 3 4 5
*Self-abusive behaviors	1 2 3 4 5	Problems with friends	1 2 3 4 5
		*Problems with gambling	1 2 3 4 5

*Explain _____
_____

- Who do you rely on for support? (ie, spouse, parents, coworkers, etc) _____

SUBSTANCE USE HISTORY:

Please complete the following regarding your drug/alcohol use history:

SUBSTANCES USED/ABUSED (such as alcohol, marijuana, vicodin, etc)	AGE OF 1ST USE	YEARS OF USE	LAST DATE OF USE	AMOUNT USED	FREQUENCY OF USE

What is your substance of preference?_____

Please answer the following questions:

☐ Yes ☐ No I can go weeks without using drugs/alcohol.
☐ Yes ☐ No I am always able to stop using drugs/alcohol if I want to.
☐ Yes ☐ No I have had black outs from drug/alcohol use.
☐ Yes ☐ No I have overdosed from drugs/alcohol.
☐ Yes ☐ No I have felt bad or guilty about my use of drugs/alcohol.
☐ Yes ☐ No Family members complain about my drug/alcohol use.
☐ Yes ☐ No My drug/alcohol use has created problems for my family.
☐ Yes ☐ No I lost friends because of my drug/alcohol use.
☐ Yes ☐ No I neglected my family because of my drug/alcohol use.
☐ Yes ☐ No I got in trouble at work/school because of my drug/alcohol use.
☐ Yes ☐ No I got in physical fights while under the influence of drugs/alcohol.
☐ Yes ☐ No I was involved in illegal activities to obtain drugs/alcohol.
☐ Yes ☐ No I have experienced withdrawal symptoms when I stopped taking drugs/alcohol.
☐ Yes ☐ No I have had medical problems as a result of my drug/alcohol use.

- Have you received treatment for a substance abuse problem before? ☐ Yes ☐ No
- If yes, where and when did you receive treatment? Please list names, places, and dates, and types of service (i.e. outpatient, inpatient, detox, methadone, residential, etc)_____
  _____
  _____

LEGAL HISTORY:

- Were you ever arrested, convicted or placed on probation? ☐ Yes ☐ No If yes, describe below:
  _____

  Age_____ Offense_____
  Age_____ Offense_____
  Age_____ Offense_____
  Age_____ Offense_____
- Are you currently on Probation/Parole? ☐ Yes ☐ No If yes, describe:_____
  _____

_____ _____
Client Signature **Date**