Life Recovered

PSYCHOSOCIAL (16 years old and up)

Client Name: _____

DOB: _____ Sex: _____ Date Completed: _____

Name of person completing this form and relationship to client: _____

Reason for seeking counseling: Please check below and list explanation if necessary.

Problems and Symptoms	Past	Present	Denied	Explanation
Change of Appetite	☐	☐	☐	
Bingeing/purging food	☐	☐	☐	
Weight loss/gain	☐	☐	☐	
Insomnia/hypersomia	☐	☐	☐	
Withdrawn	☐	☐	☐	
Depression	☐	☐	☐	
Mood Swings	☐	☐	☐	
Anxiety	☐	☐	☐	
Obsessive Thoughts	☐	☐	☐	
Compulsive Behaviors	☐	☐	☐	
Anger Management	☐	☐	☐	
Cruelty to Animals	☐	☐	☐	
Poor Memory	☐	☐	☐	
Processing Difficulty	☐	☐	☐	
Fire setting	☐	☐	☐	
Enuresis	☐	☐	☐	
Encopresis	☐	☐	☐	
Aggression	☐	☐	☐	
Lying	☐	☐	☐	
Stealing	☐	☐	☐	
Sexual Acting Out	☐	☐	☐	
Sexual Dysfunction	☐	☐	☐	
Nightmares/night terrors	☐	☐	☐	
Vivid dreams	☐	☐	☐	
Fears	☐	☐	☐	
Somatic Complaints	☐	☐	☐	
Abuse/neglect	☐	☐	☐	
Grief/loss	☐	☐	☐	
Stress	☐	☐	☐	
Flash Backs	☐	☐	☐	
Financial	☐	☐	☐	
Addictive Behavior	☐	☐	☐	
Impulsivity	☐	☐	☐	
Hyperactivity	☐	☐	☐	
Lethargic	☐	☐	☐	
Poor Concentration	☐	☐	☐	
Short Attention Span	☐	☐	☐	
Poor Family Relations	☐	☐	☐	
Poor Relations in the Workplace	☐	☐	☐	
Poor Relations with Peers	☐	☐	☐	
Hallucinations/delusions	☐	☐	☐	
Difficulty with Authority	☐	☐	☐	
Spiritual Issues	☐	☐	☐	
Feeling inadequate/Low self worth	☐	☐	☐	
Other	☐	☐	☐	

Mental Health History: (Past out patient services and hospitalizations, include dates)

_____

_____

How did it help? _____

What was your diagnosis (es)? _____

Have you ever experienced suicidal/homicidal ideations? Yes/No Intentions? Yes/No

If yes, please explain: _____

_____

Are you willing to sign a release of information for previous mental health providers? Yes/No

Significant Relationships (Circle One): Married Divorced Widowed Single Significant Other

If married/divorced how many times? _____ How long married/divorced? _____

Name children and ages: _____

On a scale of 1-10, 10 being very satisfied, rate level of satisfaction with current relationship: _____

Legal Issues: (List any past & present legal issues: i.e., arrests, convictions, bankruptcy, divorce etc. include dates)

_____

_____

Abuse History (has client been victim of any type of abuse?)**:**

Physical abuse ☐ Yes ☐ No Emotional Abuse ☐ Yes ☐ No Sexual Abuse ☐ Yes ☐ No

Domestic Violence ☐ Yes ☐ No Abandonment ☐ Yes ☐ No Neglect ☐ Yes ☐ No

Age(s) at time of abuse: _____ Treatment received: _____

Who was perpetrator? _____

Reported to Authorities? _____ Finding/disposition: _____

Did client witness any types of abuse listed above: ☐ Yes ☐ No

If yes, which type of abuse? _____

Who was the victim? _____ Who was the perpetrator? _____

Has client been the perpetrator of any abuse? ☐ Yes ☐ No Who was the victim? _____

If yes, which type of abuse? _____

Addiction/Substance Use History (If you need more space use back of page)**:**

Substance	Yes	No	Substance	Yes	No	Substance	Yes	No
Alcohol	☐	☐	Pain Pills	☐	☐	Marijuana	☐	☐
Tranquilizers	☐	☐	Stimulants	☐	☐	Inhalants	☐	☐
Sleeping Pills	☐	☐	Narcotics	☐	☐	Food	☐	☐
Hallucinogens	☐	☐	Heroin/Meth	☐	☐	Sex	☐	☐
Gambling	☐	☐	Pornography	☐	☐	Other	☐	☐

Drug of preference: _____ How long used? _____ Last used? _____

Treatment program: _____ When? _____ How long? _____ How long clean/sober? _____

Medical History (If you need more space use back of page)**:**

List any major accidents, illnesses, operations with date of occurrence: _____

_____

_____

List date and type of any head injuries or seizures: _____

_____

List current medications and reason prescribed: _____

_____

List any allergies to medications: _____

List any sexually transmitted diseases: _____

Physician:
Are you currently under a physician's care? _____
Names of Physicians/Specialists who are treating you: _____
_____
_____
_____

Education:
Highest grade completed: _____ Graduated/degree: _____
Any difficulty learning to Read: _____ Write: _____ Math: _____
Did you ever repeat a grade? Yes/No For what reason: _____
Favorite subject: _____ Most accomplished subject: _____
Circle One:
I learn best by: seeing it done reading about it hearing about it

Occupation:
Current occupation/vocation: _____ How long: _____

On a scale of 1-10, 10 being very satisfied how satisfied are you with your current occupation? _____
Please describe any difficulties you are having concerning your occupation: _____
_____
_____

Social Relationships:
How frequently do you socialize with friends? _____
How frequently do you socialize with extended family? _____
What kinds of activities do you do when you get together? _____
_____
On a scale of 1-10, 10 being very satisfied:
Rate your satisfaction with peer relationships: _____
Rate your satisfaction with extended family relationships: _____
Who do you feel is "on your side" in life? _____
Are there any people in your life you can talk to about your problems? _____
Please describe any difficulties you are having socially: _____
_____

Family History (Please list those family members with a <u>history of mental illness, learning disabilities, or addictions</u>)
(If you need more space use back of page)
Children: _____
_____
Parents: _____
_____
Siblings: _____
_____
_____
Maternal Grandparents: _____
_____
Paternal Grandparents: _____
_____
Maternal Aunts and Uncles: _____
_____
Paternal Aunts and Uncles: _____
_____

Developmental History:
Prenatal health issues: _____
_____
Birth Trauma (C-section, birth injuries, complications): _____
_____
Developmental Milestones: Describe any problems with the following:
Attachment/bonding: _____
Motor skills: _____
Toileting: _____
Speech/language: _____
Social Skills: _____
Temperament: _____

Sexual History:
Age at first sexual experience? _____
On a scale of 1-10, 10 being very satisfied, how would you rate your sexual experiences: _____
On a scale of 1-10, 10 being very satisfied, how satisfied are you with your sexual self-image: _____
On a scale of 1-10, 10 being very satisfied, how satisfied are you with the frequency of sex: _____
Please describe any sexual difficulties you are having: _____
_____
_____

Nutrition:
Do you eat a balanced diet? _____
How much caffeine do you consume daily (8 oz cups of coffee/tea, 12 oz sodas etc.)_____
How much tobacco do you smoke/chew daily? _____
How many Alcoholic drinks do you consume: 1-3 Daily 1-3 Weekly 1-3 Monthly None
How much fast food do you eat: 1-3 Daily 1-3 Weekly 1-3 Monthly None
Energy level: lethargic low average high hyperactive
How would you rate your current health: poor fair good excellent
List any food allergies you have: _____
How would you rate your weight/height/body fat ratio: poor fair good excellent
On a scale of 1-10, 10 being very satisfied, how satisfied are you with your body image
Please describe any difficulties you are having with health, nutrition, body image: _____
_____

_____

Spiritual History:
Do you believe in God? Yes No Do you believe in Jesus Christ? Yes No
Do you have a religious affiliation with which you are active? Yes No
Do you feel you have a personal relationship with Jesus Christ? Yes No
Do you believe that the Bible is God's word to mankind and contains truth for your life? Yes No
How does your faith help you to cope with life's problems? _____
_____
_____
What spiritual disciplines do you practice and how much time do you spend (i.e. prayer, Bible reading, Bible study, worship etc.)?_____
_____
Please describe any difficulties you are having concerning your faith _____
_____

_____

Goals for Counseling:

What three things would you like to change by participating in counseling?

1. _____

2. _____

3. _____

How long do you think it will take to make these changes? _____

_____

_____

What do you think it will require on your part to make these changes? _____

_____

_____

How will you know when you have accomplished your goals for counseling? _____

_____

_____

What else do you think is important for your counselor to know about you?

_____

_____

_____

_____

_____

Client Signature: _____ Date: _____