HARFORD COUNTY COUNSELING SERVICES, LLC
PSYCHOSOCIAL ASSESSMENT

I. PRESENTING
Problem

How severe would you rate your problem?
Mildly upsetting, Moderately upsetting, Very Upsetting

When did your problems begin?

What worsens the problems?

What have you tried? Has it helped?

Do you think you can get better? Yes No

What would + change look like?

II. FAMILY OF ORIGIN

a. Who is in your family? (List siblings in order & age)

b. Where were you born?

c. How would you describe your upbringing?

d. How were you disciplined by your mother/father?

e. How were you comforted?

f. Describe your father's personality and attitude towards you past and present?

g. Describe your mother's personality and attitude towards you past and present?

h. Did you feel loved and respected by your parents? Yes No

i. Have any of your family members had any history of drug or alcohol abuse (including extended relatives)? What did they use? Did they ever get clean and sober?

- What age did you start drinking/using?
- What did/do you like about drinking/using?
- How often do you currently drink/use?
- Has anyone ever suggested you get help for your drinking? Yes No
- Have you ever tried to stop drinking or using? Yes No
- Are you currently in recovery? Yes No
- How many years?
- Type of recovery program AA NA Other
- Do you have a sponsor? Yes No

j. Do any of your family members have any history of mental illness?
- Anyone ever attempt/die of suicide?
- Anyone treated for psychiatric issues?
- Anyone have long stays in the hospital?
- What is your family's understanding of your current problems?

III. DEVELOPMENTAL INFORMATION

a. Were you a wanted baby? Yes No

b. Health /Age of mother during pregnancy

c. What was happening when your mother was pregnant?

d. Born full term? Yes No Duration of labor Type of Delivery vaginal C-Section

e. Any birth complications No Yes

f. Did your mother suffer from post partem depression? Yes No

g. Do you know of any problems in the first few years of your life? What were they?

h. How were you toilet trained?

i. How did you compare to other children your age? (Size, abilities, challenges)

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IV. COGNITIVE/EMOTIONAL FUNCTIONING

Have you experienced any of the following in the past (pa) or present (pr) or both (b)?

Depression	Low Self Esteem	Sudden Fear/Anxiety
Depression in winter time only	Been bullied or you bullied someone	Panic Attacks
Repetitive thoughts can't get out of mind	Verbally abusive to others	Life threatening experience
Seeing/hearing things	Verbally abused by others	Impulsive behaviors
Repetitive behaviors you find distressful	History of being assaultive	Compulsive eating
Fatigue/lack of energy	Anger Issues	Restrictive dieting
Difficulty following through with tasks	Thoughts of hurting/ killing someone	Vomiting/Laxatives
Discomfort out in public	Cutting/Self Harm	Loss of appetite
Difficulty learning/ paying attention	Gambling addiction	Weight loss/gain
Poor Concentration	Excessive use of porn	Social anxiety
Loneliness	Suicidal thoughts/past attempts	Legal problems
Isolate	Difficulty falling asleep	Work Stress
Recent Death	Difficulty sleeping through the night	Sex Addiction
Grief	Bad dreams/nightmares	Relationship problems
Chronic pain	Do you wake up tired?	Parenting problems
Losing things, keys, phone	Controlling towards others	Financial Problems
Difficulty remembering	Controlled by Others	Spiritual Problems
Work too hard	Gender Identity Issues	Other ______________

a. Do you have any history of physical abuse? By whom?

b. Do you have any history of sexual abuse? By whom?

c. Have you experienced any other types of trauma? What happened?

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V. MEDICAL/PSYCHIATRIC INFORMATION

- Describe any physical illnesses/injuries/surgeries/hospitalizations & age
- How do you feel about your body?
- Do you like your body? Yes No
- Are there times you don't like your body? Yes No
- Do you have any physical sensations/pain/concerns that are related to past traumas?
- What kind of medications are you currently taking? What are they for?
- Do you currently have any medical concerns?
- When was your last physical exam? Gyn exam? Dental exam?

Have you met with any other Mental Health Professional? (Psychologist/ Social Worker)?

Name	Duration	Reason Ending	Helpful/Not Helpful

- What characteristics do you look for in a therapist?

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VI. MARRIAGE/COMMITTED RELATIONSHIP

a. How long did you know your spouse/partner before your engagement/living together? How long have you been married/living together?

b. Describe your spouse/partner's personality. What do you like most about your partner? What do you like least?

On a scale of 1-10, how satisfied are you with your relationship? 1-very dissatisfied to 10 -very satisfied

1 2 3 4 5 6 7 8 9 10

Any significant details about your previous serious relationships/marriages?

VII. SEXUAL HISTORY

- How old were you when you sexually developed?
- How did your parents handle your sexual development?
- How old were you when you first had sexual intercourse? What was the experience like for you?
- What is your sexual orientation?
- What pronoun do you prefer?
- Who are your current sexual partner(s)?
- Is this relationship satisfying? Yes No
- Do you have any problems such as lack of interest , difficulty with erections/orgasms, pain during intercourse, fantasies or practices that you are uncomfortable with? (Check all apply)
- Have you had any sexual difficulty or abuse in previous relationships? Yes No
- Have you or your partner ever had an abortion? Yes No

VIII. SOCIAL RELATIONSHIPS/LEISURE:

- With whom do you spend most of your free time? How many close friends do you have?
- Who is supportive to you in your life?
- What do you enjoy doing? How do you relax?
- What do you see as your strengths?
- What do you see as your weaknesses?
- What do you consider stressors in your life?

IX. SPIRITUAL HISTORY

- Describe your sense of purpose, connection to a higher power/God.
- Do you attend a church or other place of worship?
- Are you currently satisfied with where you are with your spirituality? Yes No
  If no, what would you like to see change in your spirituality?

X. EDUCATION/EMPLOYMENT INFORMATION

a. Highest Education Level
b. Currently in school? Yes No Studying
c. Currently employed? Yes No Where
d. Any concerns with your employment?
e. Scholastic Strengths
f. Scholastic weaknesses
g. Military History Yes No

Emergency Contact:

Phone Number:

Can we notify above person in case of a clinical/medical emergency? Yes No

5 BEST INCIDENTS IN YOUR LIFE

1.

2.

3.

4.

5.

TREATMENT GOALS

Short Term Goals of Therapy

1

2

3

4

Long Term Goals of Therapy

1

2

3

4

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10 MOST DISTURBING INCIDENTS IN YOUR LIFE

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

TOP THREE NEGATIVE CORE BELIEFS

1.
2.
3.

For Clinician Use Only

Reviewed Psychosocial: Date: