Crawford consulting and mental health services, inc
ADULT PSYCHOSOCIAL ASSESSMENT

The following necessary information will help make your first session most productive, Signed consent is required from the parent(s) or legal guardian before treatment can be provided. If you are court-mandated to receive counseling, bring the court order or case plan. Please bring all documents to the first session. Thank you.

Date of assessment: _______________

DEMOGRAPHICS

____

Last Name First Middle

____

Residence Address City State Zip Code

____

Date of Birth Age Social Security Number

____

Telephone (Home) (Cell) (Parent/Guardian)

Sex:
☐Male ☐Female

Martial Status:
☐ Single ☐ Married ☐ Separated ☐ Divorced
☐ Remarried ☐ Partnered ☐ Widowed

PERSONAL HISTORY

In your own words, why are you seeking treatment at this time?

____
____
____

What are your top three strengths?

____
____

What would you like to change about yourself or circumstances?

____
____

What are some things you are willing to do to help with your recovery?

____
____

What gives you hope, purpose, and meaning to life?

____
____

What do you need help with? (Check all that apply)

☐Anger Management	☐Depression	☐Housing
☐Trauma/Abuse	☐Anxiety	☐School
☐Substance use/abuse	☐Grief/Death/Loss	☐Family
☐Legal/Juvenile Justice	☐Marriage/Significant other	☐Psychosis
☐Employment/School	☐ ADHD	☐Mood Swings
☐ Medical/Physical	☐ PTSD	☐ Children/Parenting
☐Extramarital Relationship	☐ Autism	☐Other_______________________

MENTAL HEALTH

Have you had any of the following within the past 90 days? (Check all that apply)

☐Suicidal thoughts	☐Depression	☐Racing thoughts
☐Suicidal attempts	☐Death in family	☐Panic/phobia
☐Self injury	☐Hyperactivity	☐Hospitalization
☐Obsessive/intrusive thoughts	☐Paranoia/Delusions	☐Poor sleep patterns
☐Thoughts of harming others	☐Mood swings	☐Weight gain/loss
☐Violence	☐Anxiety	☐Hallucinations (voices/visions)

Do you have any thoughts of self – harm? ☐Yes ☐No
Do you have any thoughts of harming others? ☐Yes ☐No

Have you ever been in counseling before? ☐Yes ☐No
If yes: ____
Date Location Counselor

Are you currently taking behavioral health medications? ☐Yes ☐No
If yes, please list:____

Have you ever taken behavioral health medications? ☐Yes ☐No
If yes, please list:____

Have you ever been hospitalized for behavioral health reasons? ☐Yes ☐No
If yes, please list: ____
Date Location Doctor

What are your previous mental health diagnoses?
____

Is there any family history of mental health problems or suicide (attempts)?
If yes, please explain:____

SUBSTANCE USE

Explain any family history of substance abuse:

Have you used or are you currently using any drugs or alcohol? ☐Yes ☐No
If no, skip to next section
Do you feel that you should be cut down on your substance use? ☐Yes ☐No
Have you ever felt bad or guilty about your substance use? ☐Yes ☐No
Have you ever tried to stop and have been unsuccessful? ☐Yes ☐No
If yes: ____
Date Circumstances

Have you ever had a drink or used drugs first thing in the morning to steady your nerves, get rid of a hangover, or get the day started? ☐Yes ☐No

Have you ever had a blackout while using drugs or alcohol? ☐Yes ☐No

What consequences have you suffered because of you substance use? (Check all that apply)

☐Financial ☐Employment/School ☐Physical health
☐Legal ☐Relationships ☐Mental health

Have you ever had any substance abuse treatment? ☐Yes ☐No
If yes: ____
Date Type Location/Counselor

Did prior substance abuse treatment help? ☐Yes ☐No
Please explain____

MEDICAL

Who is your primary care physician?

____
Doctor Address/Location

Do you currently have any medical problems? ☐Yes ☐No

Please list your symptoms and medications:

____
____

Does your physical pain cause mental health issues? ☐Yes ☐No
Have you recently experienced appetite changes? ☐Yes ☐No
Have you recently had a gain or loss of over 10 lbs? ☐Yes ☐No

FOR FEMALES
Are you pregnant? ☐Yes ☐No
If yes how many months? ______________________________
Have you given birth within the past 12 months? ☐Yes ☐No

SOCIAL/VOCATIONAL/SUPPORT SYSTEM

Describe leisure/recreational activities: ____

____

Are you currently employed? ☐Yes ☐No
If yes: ____
Employer Monthly Salary Length of employment

What is your highest level of education completed?________________________________

Are there any problems at work? ☐Yes ☐No
If yes please explain:____

Are you currently a student?
If yes: ____
Grade level School

Who is your support system?

____

Is your current home environment safe? ☐Yes ☐No
If no, describe the details:____

What do you hope to gain out of treatment?

____

____

LEGAL

How many times have you been arrested in the past two years? _________________________

Are you court ordered for services? ☐Yes ☐No
If yes: ____
Name Phone Number

What is your legal status? ____________________________________

When is your next court date? __________________________________

Will you require a progress note for legal authorities? ☐Yes ☐No
If yes: ____
Name Location Phone

FAMILY HISTORY

Who were you raised by? ____

Describe your relationship with your parents:

____

____

How many siblings do you have? _____Brothers _____Sisters

My relationship with my siblings is:

☐Good ☐Fair ☐Poor ☐Not applicable

Are you living with your spouse or partner at present? ☐Yes ☐No

Describe your relationship with your spouse or partner:

____

____

How many children do you have? ___________________________ Ages:__________________________

Describe your relationship with your children:

____

____

Please list all family members and ages that will be involved in treatment:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Client Name Client Signature