CHRISTIAN COUNSELING CENTER OF BATTLE CREEK

Psychosocial Assessment

Age 16 and Above

Name: _____ Record# _____

Age: _____ Sex: _____ Clinician: _____

DIRECTIONS: Please answer the following questions as fully as possible.

Problem Assessment:

Present Problem/Stressors: *Please list all that apply:*

Marital issues Health issues Job issues Financial issues
Parent/child issues Issues of past (guilt, abuse, neglect, family of origin issues , etc.)
Other _____

Symptoms: *Please list all that apply:*

Change in sleep pattern	Depressed mood	Mood swings
Decreased energy	Decreased interest or pleasure	Anger problems
Decreased concentration	Change in appetite	Thoughts of death
Decreased motivation	Anxiety/Worry/Panic	

Other_____

Suicidal/Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? ☐ yes ☐ no If yes, how?
_____
Is there a history of suicide in your nuclear and/or extended family? ☐ yes ☐ no
Have you ever inflicted burns or wounds to yourself? ☐ yes ☐ no
Are you presently suicidal/homicidal? ☐ yes ☐ no
Any other risk taking behaviors that you engage in? ☐ yes ☐ no
If yes, please explain_____

What event(s) in the recent past has/have prompted you to seek counseling? _____
_____
_____

Describe additional problems you are experiencing._____
_____
_____
_____

When did these problems develop? _____
_____
_____

List any recent losses you have experienced.

Family Health Disruption of lifestyle Job Significant other
Other _____

List your strengths and weaknesses.

Strengths	Weaknesses
_____	_____
_____	_____
_____	_____
_____	_____

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Psychosocial Assessment

Age 16 and Above

Psychiatric History:

Have you ever had any previous outpatient counseling? ☐ yes ☐ no If yes, please complete information below.

Place	Length of Time	Date(s)

Have you ever been admitted to the hospital for mental health or addiction issues? ☐ yes ☐ no

Place _____ Dates _____

Name of current doctor and/or therapist _____

Have you ever received a psychiatric diagnosis? ☐ yes ☐ no

Please explain _____

Do you feel medications you have been on, past or present, have been effective? ☐ yes ☐ no

Please explain _____

List all medications you have taken *in the past* for anxiety, depression, and/or sleep. _____

_____

Medical Information:

How would you describe your current condition of health? _____

Do you have any disabilities and/or disorders? ☐ yes ☐ no

If yes, explain _____

Explain any special adjustments needed for the disability or disorder: _____

_____

Are you currently on any medication? ☐ yes ☐ no

Name of medication	Dosage/Frequency	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications or have you ever had an adverse reaction to medication? ☐ yes ☐ no

If yes, please list _____

Has it been more than a year since your last physical exam including blood tests? ☐ yes ☐ no

Have you ever had an abortion? ☐ yes ☐ no Males: Has a child of yours ever been aborted? ☐ yes ☐ no

Do you have allergies? ☐ yes ☐ no If yes, explain _____

List any previous health problems, operative procedures, and medical hospitalizations:

Problem	Dates	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Substance Abuse History:

Describe your current usage, or usage within the past year (includes alcohol, any illegal drugs, caffeine, and tobacco).

Substance	Amount	Frequency	Age of 1st use	Age regular use started	Last use
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

CHRISTIAN COUNSELING CENTER OF BATTLE CREEK

Psychosocial Assessment

Age 16 and Above

Have you experienced a recent increase in the use of alcohol and/or other substances? ☐ yes ☐ no
Do you, your family, or your friends see your current usage as a problem? ☐ yes ☐ no If yes, when did it become problematic? _____
Please describe any previous experience with drugs or alcohol._____
_____
_____

Describe any significant family history of substance abuse. _____
_____
_____

Nutrition:

Do you feel you have balanced, healthy eating patterns? ☐ yes ☐ no
Do you have a lot of concerns about your weight and shape? ☐ yes ☐ no
Do you often eat out of depression, boredom, anger? ☐ yes ☐ no
Do you ever binge eat or fear losing control of your eating? ☐ yes ☐ no
Do you ever self-induce vomiting? ☐ yes ☐ no
How do you feel about eating with others in a group? _____
Do you use laxatives, water pills (diuretics), or diet medications to control your weight? ☐ yes ☐ no
Do you or others believe you exercise excessively? ☐ yes ☐ no

Legal History:

Please explain all that apply:

Charges as a minor _____
Charges presently _____
Arrests (How many) _____
Incarcerations (How many) _____
Parole _____
Convictions (How many) _____
Probation _____
Bankruptcy _____
Civil Suits _____
Child Custody Problems _____

Developmental History:

List members of your family of origin and comment on how you got along with each one.

Name	Relationship	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What was your birth order? _____ of _____ children Who primarily raised you?_____
How would you describe your childhood? ☐ Traumatic ☐ Painful ☐ Uneventful ☐ Good ☐ Happy
What were you like as a child (include friends, school, hobbies, and personality)? _____
_____
_____

CHRISTIAN COUNSELING CENTER OF BATTLE CREEK

Psychosocial Assessment

Age 16 and Above

Were there any unusual or traumatic experiences for you as a child?

Date Age Event

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever been the recipient of unwanted sexual acts? ☐ Yes ☐ No

If yes, please explain_____

Have you ever been the victim of abuse, neglect, or violence? ☐ Yes ☐ No

If yes, please explain_____

Have you ever been the perpetrator of abuse, neglect, or violence towards another person? ☐ Yes ☐ No

If yes, please explain_____

What is your sexual orientation? Heterosexual Homosexual Bisexual

Living Arrangements:

☐ Satisfactory? ☐ Unsatisfactory?

Where do you currently live? _____ How long there? _____

With whom are you living? _____

Describe your current relationships with family members: _____

_____

_____

_____

Social Relationships/Support System:

Who can you count on for support? *List as many as apply.*

Parents Spouse Siblings Employer Church Pastor Therapist Neighbor(s)

Extended Family Close Friend Self-help Group Community Services Co-Worker Medical Dr.

Do you have close friends (outside of family)?_____

What are your hobbies or leisure activities?_____

_____

Marital History (if applicable):

When were you married? _____ Name and age of spouse _____

Previous marriage(s) ☐ yes ☐ no If yes, date of divorce(s) _____

Children from this marriage? _____

What is your perception of your current marriage (include communication patterns, problems, sexual relations).

_____

_____

_____

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Psychosocial Assessment

Age 16 and Above

List names and ages of children:

How do you get along with each one?

Name	Age	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Financial Situation:

Describe briefly your financial situation. _____

_____

_____

_____

Religious/Cultural Factors:

What is your religious background? _____

Describe the religious atmosphere in your home (past or present): _____

_____

_____

Do you currently attend church, synagogue, or mosque? ☐ yes ☐ no

What does God seem like to you?_____

_____

Describe your relationship with God: _____

_____

_____

What do you consider to be the role of God in your recovery?_____

_____

Please list any issues (positive or negative) which are important or may have affected you in regard to religion or ethnic/cultural background.

_____

_____

_____

Educational History:

What was school like for you? _____

_____

Highest level achieved _____ What type of grades did you make? _____

Currently in school? ☐ yes ☐ no If yes, what level? _____

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Psychosocial Assessment
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Work Adjustment History:
Describe your current job/career_____
_____

Would you enjoy doing this job on a long-term basis?_____
How do you deal with authority figures? _____
_____
Describe your relationship with co-workers _____
_____
Describe your job performance _____
_____
Have you ever been fired or laid-off? ☐ yes ☐ no If yes, explain _____
_____
How many jobs have you held within the previous five years? _____

Military History:
List branch, dates, and duties.
_____
_____
_____

Family:
Would it be beneficial for any member(s) of your family/legal guardian to be involved in your treatment?
☐ yes ☐ no
If yes, explain who and why. _____
_____
_____

May we contact any of the person's you have mentioned above for their input and involvement in your care?
☐ yes ☐ no

What is your family/legal guardian's perception of your difficulties? _____
_____
_____

Miscellaneous:
Are there any other things that can be helpful for us to know about you? _____
_____
_____
_____
_____

Is there anyone else that it would be appropriate, and you would permit us, to contact in regard to your care?
☐ yes ☐ no If yes, please give their name and phone number:_____

CHRISTIAN COUNSELING CENTER OF BATTLE CREEK

Psychosocial Assessment

Age 16 and Above

Is there anyone that we are legally required to notify in regard to your care? ☐ yes ☐ no
If yes, please give us the necessary information to contact them._____
_____

Is there a need for assistive technology in your treatment? ☐ yes ☐ no If yes, what is that need? _____
_____

What would you like to accomplish during your treatment with CCCBC? _____
_____
_____
_____

_____ _____
Signature Date

Read and Reviewed by _____ Date: _____
(Clinician)

Revised 02/07

Submit