

David L. Henderson, M.D.
PSYCHOSOCIAL ASSESSMENT
Age 15 and Above

Name: _____

Record# _____

Age: _____ Sex: _____ Date of Birth: _____

Referral Source _____ Address _____

Phone # _____ Fax # _____ Do I have your permission to release information to the referring professional when it is appropriate? Yes _____ No _____

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

Problem Assessment:

Present Problem/Stressors: *Please describe the main reason(s) for seeking treatment at this time:*

Symptoms: *Please complete the symptoms Checklist provided in your initial paperwork.*

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 contributed to your current condition? _____

Describe additional problems you are experiencing. _____

When did these problems develop? _____

Psychiatric History:

Have you ever had any previous outpatient psychiatric treatment? yes no

Places/Dates _____

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

Places/Dates _____

Name of previous doctors and/or therapists _____

Have you ever received a psychiatric diagnosis? yes no

Please explain _____

Please list psychiatric medications that you have taken, past or present. Include dosages, effectiveness, and any side effects (Please attach a separate sheet of paper if necessary):

Date Taken	Medication	Effectiveness	Side-effects/Problems
Ex: 2/2000 – 5/2004	Ex: Cymbalta 30mg once a day	Ex: improved my mood but did not help with my anxiety	I was nauseated all the time.

Medical Information:

Current Medical Problems:

Current Nonpsychiatric medications/supplements:

Past Medical Problems:

Other doctors/clinics seen regularly: _____

Any History of head trauma (describe): _____

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

If yes, please list _____

Current Life Stresses: (include anything that is currently stressful for you; examples include relationships, job, school, finances, children)

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

<u>Substance</u>	<u>Amount</u>	<u>Frequency</u>	<u>Age of 1st use</u>	<u>Age regular use started</u>	<u>Last use</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please describe any previous experience with drugs or alcohol. _____

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 any legal problems you have had past or present:

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:

What was your birth order? _____ of _____ children Who primarily raised you? _____

How would you describe your childhood? Traumatic Painful Uneventful Good Happy

Were there any unusual or traumatic experiences for you as a child? (Including physical, sexual, or verbal abuse)

<u>Date</u>	<u>Age</u>	<u>Event</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Sexual History: (Answer only as much as you feel comfortable)

Age at the time of first sexual experience: _____ Number of sexual partners: _____
Any history of sexually transmitted diseases? _____ History of abortions? _____
History of sexual abuse, molestation or rape? _____
Current Sexual Problems? _____
What is your sexual orientation? Heterosexual Homosexual Bisexual

Family History:

Are there any psychiatric illnesses that run in your family?

Are there any addictive behaviors that run in your family? (ex: drugs, alcohol, sexual, gambling)

Are there any medical problems that run in your family?

Living Arrangements:

Where do you currently live? _____ How long there? _____
With whom are you living? _____

Social Relationships/Support System:

Who can you count on for support? _____

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) _____
Any children from this marriage? _____

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

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

Describe your relationship with God: _____

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

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 growing up? _____

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

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

Work Adjustment History:

Describe your current job/career _____

List all of the jobs you have held within the previous five years?

Military History:

List branch, dates, and duties. _____

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: _____

What would you like to accomplish during your treatment?

Signature _____

Date _____

Read and Reviewed by _____, Clinician, on _____