

## ***Adult Psychosocial***

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**CHIEF COMPLAINTS** (please mark all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Abuse (physical, sexual, emotional)       | <input type="checkbox"/> Judgement problems, risk taking          |
| <input type="checkbox"/> Aggression, violence                      | <input type="checkbox"/> Legal matters, charges                   |
| <input type="checkbox"/> Alcohol use                               | <input type="checkbox"/> Loneliness                               |
| <input type="checkbox"/> Anger, hostility, arguing                 | <input type="checkbox"/> Marital conflict, infidelity, remarriage |
| <input type="checkbox"/> Anxiety, nervousness                      | <input type="checkbox"/> Memory Problems                          |
| <input type="checkbox"/> Attention, concentration, distractibility | <input type="checkbox"/> Menstrual Problems, PMS, Menopause       |
| <input type="checkbox"/> Career concerns, goals, choices           | <input type="checkbox"/> Mood swings                              |
| <input type="checkbox"/> Childhood Issues                          | <input type="checkbox"/> Motivation, laziness                     |
| <input type="checkbox"/> Children, child care, parenting           | <input type="checkbox"/> Nervousness                              |
| <input type="checkbox"/> Codependence                              | <input type="checkbox"/> Nightmares                               |
| <input type="checkbox"/> Confusion                                 | <input type="checkbox"/> Obsessions, compulsions                  |
| <input type="checkbox"/> Compulsions                               | <input type="checkbox"/> Oversensitivity to rejection             |
| <input type="checkbox"/> Custody of children                       | <input type="checkbox"/> Panic or anxiety attacks                 |
| <input type="checkbox"/> Decision making, indecision               | <input type="checkbox"/> Perfectionism                            |
| <input type="checkbox"/> Delusions (false ideas)                   | <input type="checkbox"/> Pessimism                                |
| <input type="checkbox"/> Dependence                                | <input type="checkbox"/> Procrastination, work inhibitions        |
| <input type="checkbox"/> Depression, sadness, crying               | <input type="checkbox"/> Relationship Problems                    |
| <input type="checkbox"/> Divorce, separation                       | <input type="checkbox"/> School Problems                          |
| <input type="checkbox"/> Drug use                                  | <input type="checkbox"/> Self-centeredness                        |
| <input type="checkbox"/> Eating Problems                           | <input type="checkbox"/> Self-esteem                              |
| <input type="checkbox"/> Emptiness                                 | <input type="checkbox"/> Self-neglect, poor self-care             |
| <input type="checkbox"/> Failure                                   | <input type="checkbox"/> Sexual issues, dysfunctions, conflicts   |
| <input type="checkbox"/> Fatigue, tiredness, low energy            | <input type="checkbox"/> Shyness, oversensitivity to criticism    |
| <input type="checkbox"/> Fears, phobias                            | <input type="checkbox"/> Sleep problems (too much, too little)    |
| <input type="checkbox"/> Financial or money problems               | <input type="checkbox"/> Smoking, tobacco use                     |
| <input type="checkbox"/> Friendships                               | <input type="checkbox"/> Stress, relaxation, tension              |
| <input type="checkbox"/> Gambling                                  | <input type="checkbox"/> Suspiciousness                           |
| <input type="checkbox"/> Grieving, mourning, losses                | <input type="checkbox"/> Suicidal thoughts                        |
| <input type="checkbox"/> Guilt                                     | <input type="checkbox"/> Temper problems, self-control            |
| <input type="checkbox"/> Headaches, other pain                     | <input type="checkbox"/> Thought disorganization and confusion    |
| <input type="checkbox"/> Health, illness, medical concerns         | <input type="checkbox"/> Threats, violence                        |
| <input type="checkbox"/> Inferiority feelings                      | <input type="checkbox"/> Weight and diet issues                   |
| <input type="checkbox"/> Interpersonal conflicts                   | <input type="checkbox"/> Withdrawal, isolating                    |
| <input type="checkbox"/> Impulsiveness, outbursts                  | <input type="checkbox"/> Work problems, employment, workaholism   |
| <input type="checkbox"/> Irresponsibility                          |   |

How long have these problems occurred? (number of weeks, months, years) \_\_\_\_\_

What happened that makes you seek help at this time? \_\_\_\_\_

---

Problems perceived to be: \_\_\_\_\_very serious \_\_\_\_\_serious \_\_\_\_\_not serious

**A. Treatment:**

Have you ever received psychological or psychiatric or counseling services before? \_\_\_\_NO \_\_\_\_YES

If yes, When, For What, Describe Results: \_\_\_\_\_

\_\_\_\_\_

Have you ever taken medications for psychiatric or emotional problems? \_\_\_\_NO \_\_\_\_YES

If yes, When, From Whom, For What, Describe Results: \_\_\_\_\_

\_\_\_\_\_

**B. Relationships in your Family of Origin: Please describe the following:**

1. Your parents' relationship with each other: \_\_\_\_\_

\_\_\_\_\_

2. Your relationship with each parent: \_\_\_\_\_

\_\_\_\_\_

3. Your parents' physical health problems, chemical use, and mental or emotional difficulties: \_\_\_\_\_

\_\_\_\_\_

4. Your relationship with your brothers and sisters, in the past and present: \_\_\_\_\_

\_\_\_\_\_

**C. Abuse History:**

\_\_\_\_I was not abused in any way. \_\_\_\_I was abused.

If you were abused, please indicate the type of abuse: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**D. Present Relationships:**

1. How do you get along with your present spouse or partner? \_\_\_\_\_

\_\_\_\_\_

2. How many children do you have? \_\_\_\_\_

3. Names and ages: \_\_\_\_\_

\_\_\_\_\_

2. How do you get along with your children? \_\_\_\_\_

\_\_\_\_\_

3. Do you have a social support system? Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**E. Chemical Use:**

1. Have you ever felt the need to cut down on your drinking?      \_\_\_\_NO      \_\_\_\_YES
2. Have you ever felt annoyed by criticism of your drinking?      \_\_\_\_NO      \_\_\_\_YES
3. Have you ever felt guilty about your drinking?      \_\_\_\_NO      \_\_\_\_YES
4. Have you ever taken a morning “eye-opener?”      \_\_\_\_NO      \_\_\_\_YES
5. How much beer, wine, or hard liquor do you consume each week, on the average? \_\_\_\_\_  
\_\_\_\_\_
6. How much tobacco do you smoke or chew each week? \_\_\_\_\_
7. Which drugs (not medications prescribed to you) have you used in the last 10 years? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**F. Legal History:**

Have you ever been arrested, placed on probation or parole in the past, or incarcerated?

\_\_\_\_\_

**G. Other:**

Is there anything else that is important for me as your therapist to know about, and that you have not yet informed me about on any of these forms? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_