JORDAN THERAPY SERVICES, LLC
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Psychosocial Assessment

Service Date: _____ Start Time: _____ Stop Time: _____

Client Name: _____ Date of Birth: _____
Age: _____ Sex: _____

Communication Preferences:
What is the best phone number to contact you? _____
Do you authorize your therapist to leave voicemail messages? Yes ___ No ___
Do you give permission for your therapist to text you with appointment reminders?
Yes ___ No ___
What is your email address? _____
Do you authorize your therapist to utilize this email? Yes ___ No ___
What is your physical address? _____
Do you authorize your therapist to send mail to your physical address on file?
Yes ___ No ___
Referral Source: ___ Psychology Today ___ MyTherapistMatch.com
___ GoodTherapy.Org ___ Insurance Provider look up ___ Google Search
___ Other (please describe) _____

Directions: Please answer the following questions as completely as possible.

PRESENTING PROBLEM: (Briefly describe the issues/problems which led to your decision to seek therapy/counseling services.)
_____
_____
_____
_____
_____

Symptoms: (Please check all that apply)

- Change in sleep pattern
- Decreased motivation
- Decreased concentration
- Lack of concentration
- Change in appetite
- Mood swings
- Behavioral problems
- Increased anxiety

Other:
_____
_____

Suicidal/Homicidal Ideation:
Have you ever attempted to commit suicide or homicide in the past?
_____
If yes, how?_____
Is there a history of suicide in your nuclear and/or extended family?
_____
Have you ever inflicted burns and/or wounds on yourself?
_____
Are you presently suicidal/homicidal?
_____

Recent Losses: (Please check all that apply)

- Family
- Health
- Disruption in lifestyle
- Job
- Significant other

Other: _____

PSYCHIATRIC/PSYCHOLOGIAL HISTORY:

Please list any and all previous outpatient counseling experiences.
Place _____
Reason _____
Length of time _____
Dates _____

Place _____
Reason _____
Length of time _____
Dates _____

Place _____
Reason _____
Length of time _____
Dates _____

Have you ever been admitted to the hospital for mental health or addiction issues?
_____
Place _____
Reason _____
Length of time _____
Dates _____

Name of current psychiatrist
_____

Other/more:
_____
_____
_____

Mental Health History of Relatives (Diagnosis and treatment)
_____
_____
_____

MEDICAL HISTORY:
(Include significant medical problems, hospitalizations, surgeries, physical limitations, sleep problems, unusual eating habits, poor hygiene, overall physical fitness, head injuries, early childhood infections, eating disorders, knee or back injuries, asthma, etc…):
_____
_____
_____
_____

Current Medications (including psychotropic, over-the-counter-herbal remedies):
(include all meds taken over the last 6 months)

Medication	Dosage	Frequency	Prescribed by	Reason for taking

Is individual compliant with medications? _____
If no, please explain:
_____
_____

Allergies:

_____
_____

Current primary physician and facility:

_____
_____

Family Composition/Environment:
Please list names, ages, relationships and other relevant information regarding the immediate family whether living in- or outside the home. In blended families, please include child/parent and child/sibling relationships.

Name	Sex: M/F	Age	Marital Status	How related to client	Living inside or outside of home	Education	Occupation

Marital History (if applicable):

_____
_____
_____

Comments regarding family:

_____
_____
_____

Developmental History (if client is under 18)
Age walking? _____ Age talking? _____
How active as baby?

_____

Personality of Child: (shy, restless, overactive, withdrawn, outgoing, timid, athletic, etc…)

_____
_____
_____

Significant disturbances during childhood: (including losses, family illness, separation, tantrums, etc.)

_____
_____
_____

Physical, Sexual Abuse or Neglect:
Has client ever been assaulted or abused physically, sexually, or emotionally?
Yes _____ No _____ Unknown _____
If yes, please state by whom, the dates, and if case was reported to proper authorities.

_____

Has client ever been accused of assaulting or abusing someone physically, sexually, or emotionally?
Yes _____ No _____ Unknown _____
If yes, please state by whom, the dates, and if case was reported to proper authorities.

_____

EDUCATION:
Highest grade completed _____
Current school (if applicable) _____
Does the client have any diagnosed learning disabilities?
Yes _____ No _____
What is the client's achievement and attitude toward school/education?

_____
_____
Discipline Issues: _____
_____

Comments:

_____
_____

EMPLOYMENT HISTORY (if applicable):

_____
_____
_____

Legal Involvement:
No legal involvement ____ Parole ____ Probation ____
Charges pending ____ Previous jail ____

Probation Officer's Name: _____

Please list any past or present involvement with the legal system including arrests, probation, community service/education, court diversion programs, etc. List any upcoming court dates, probation appointment etc. including names and phone number of contact persons:

_____
_____
_____

DRUG/ALCOHOL ASSESSMENT

SUBSTANCE USE HISTORY

(include experimentation & accidental ingestion. Include alcohol, tobacco, and caffeine)

Drug	Method	Age 1st used	Age last used	Onset of heavy use	# Days used in last 30	Amount used in last 48 hours	Amount used daily/weekly	Last used when?	Drug of choice? Y/N

Any changes in patterns of use over time? Yes _____ No _____
Does individual ever drink more than he/she intends? Yes _____ No _____
Has individual experienced an increase in the amount he/she can use to get the same effect?
Yes _____ No _____
Is there a history of overdoes? Yes _____ No _____
Is there a history of seizures? Yes _____ No _____
Is there a history of blackouts? Yes _____ No _____
Has individual ever used medications to either get high or come down from being high?
Yes _____ No _____
With whom does individual usually use? Yes ____ No ____
Has individual had previous substance abuse treatment? Yes ____ No ____
Assessment of risk in this area:

_____

CLIENT STRENGTHS/WEAKNESSES

In your opinion, what are your (or your child's) strengths? -

_____
_____
_____

In your opinion, what are your (or your child's) limitations?

_____
_____
_____

SUPPORT SYSTEM

Who can you count on for support? (Check all that apply)

- Parents
- Spouse
- Siblings
- Employer
- Church
- Therapist
- Neighbor
- Extended Family
- Close Friend
- Self Help
- Group
- Community Services
- Co-Worker
- Medical Doctor

Individual completing assessment:

Printed Name _____ Relationship _____

Signature _____