Name: _____

Psychosocial Assessment

Stated reason for visit:

_____

_____

_____

Since intake assessment/last attendance in program, have you wished you were dead or wished you could go to sleep and not wake up? ___ Yes or ___No

Since intake assessment/last attendance in program, have you actually had any thoughts of killing yourself? ___ Yes or ___No

Since intake assessment/last attendance in program, have you been thinking about how you might do this? ___ Yes or ___No

Since intake assessment/last attendance in program, have you had these thoughts and had some intention of acting on them? (As opposed to I have thoughts but would never do anything about them? ___ Yes or ___No

Since intake assessment/last attendance in program, have you started to work out or worked out the details of how to kill yourself and intend to carry out this plan? ___ Yes or ___No

Since intake assessment/last attendance in program, have you done anything, started to do anything, or prepared to do anything to end your life (collected/hoarded pills, given away valuables, written a suicide note, tried to shoot/cut/hang yourself)? ___ Yes or ___No

Are you having any homicidal or violent thoughts? Please check all that apply.

___ Current
___ Past 6 months
___ Lifetime

___ None currently
___ None in past 6 months
___ None in lifetime

If having homicidal thoughts, please describe thoughts/plans/means/intent.

_____

_____

_____

Do you have possession/access to weapons? ___ Yes or ___ No If yes, what kind of weapons? _____

_____

Have you had any alcoholic beverages in the last 12 months? ___ Yes or ___No

How often do you have a drink containing alcohol?

___ Never
___ Monthly or less
___ 2-4 times a month
___ 2-3 times per week
___ 4 or more times a week

What is the number of alcoholic drinks you typically have in a day, *if you are drinking?*

___ 1 or 2
___ 3 or 4
___ 5 or 6
___ 7 to 9
___ 10 or more

How often do you have 6 or more drinks on one occasion?

___ Never
___ Less than monthly
___ Monthly
___ 2-3 times per week
___ 4 or more times per week

What type of alcohol do you use? _____

What is your method for acquiring alcohol? Check all that apply.

___ Barters or trades to obtain
___ Have others buy for you
___ Makes own alcohol
___ Purchases independently
___ Steals

How often do you drink? _____

When was your last drink? _____

Have you had any problems resulting from your alcohol use?

___ None identified
___ Financial
___ Legal
___ Family problems
___ Loss of job
___ School Issues
___ Social Problems

Do you believe alcohol is a problem for you? ___ Yes or ___ No

Have you used any drugs or illegal substances in the last 12 months? ___ Yes or ___ No

If Yes, which substance(s) have you used?

___ Amphetamines
___ Barbiturates
___ Benzodiazepines
___ Cocaine
___ Codeine
___ Crack
___ Inhalants
___ Methadone
___ Fentanyl
___ Heroin
___ Hydrocodone
___ LSD
___ MDMA (ecstasy)
___ Marijuana
___ Buprenorphine
___ Methamphetamines
___ Morphine
___ Nitrous Oxide
___ Opium
___ Oxycodone
___ PCP
___ Buprenorphine/Naloxone

What is your method for acquiring substances? Please check all that apply.

___ Barters or trades to obtain
___ Have others buy for you
___ Makes own alcohol
___ Purchases independently
___ Steals

How much do you use per week for each substance? _____

_____

When was your last use? _____

Have you had any problems resulting from your drug use?

___ None identified
___ Financial
___ Legal
___ Family problems
___ Loss of job
___ School Issues
___ Social Problems

Do you believe drugs are a problem for you? ___ Yes or ___ No

Have you engaged in any addictive behaviors in the past 12 months? ___ Yes or ___No

Please check all that apply below, only check if you engage in these behaviors in an unhealthy way (interferes with your activities of daily living):

___ Eating
___ Gambling
___ Gaming
___ Internet
___ Pornography
___ Sex
___ Shopping

What is your method of engaging in addiction? Please check all that apply.

___ Barters or trades to obtain
___ Have others buy for you
___ Makes own
___ Purchases independently
___ Steals items

How often have you engaged in this addictive behavior? _____

_____

When is the last time you engaged in this addictive behavior? _____

_____

Have you had any treatment for any addictions in your lifetime? If yes, please list prior dates and locations.

_____

_____

Current caffeine use: ____Yes or ____No

Types of caffeine:

___ Coffee ___ Tablets
___ Energy Drink/Supplements ___ Tea
___ Soft Drinks

Amount of caffeine per day:

_____

_____

Have you used tobacco products in the last 30 days? ___ Yes or ___No

Do you have any significant legal issues? ___ Yes or ___ No If yes, please describe.

_____

_____

Do you have any prior psychiatric hospitalizations?

_____

_____

Are you currently attached to any outpatient providers?

Primary Care Physician _____

Individual Counselor _____

Psychiatrist _____

Case Manager _____

Probation/Parole Officer/Lawyer _____

Do you have any family psychiatric history? ___ Yes or ___ No If yes, which family member(s) and what type of mental illness?

_____

_____

Do you have any family history of suicide? ___ Yes or ___ No If yes, which family member(s)?

_____

_____

Do you have any family history of addiction? ___ Yes or ___ No If yes, which family member(s)?

_____

_____

What is your marital status?

___ Divorced
___ Domestic Partner
___ Married
___ Separated
___ Single, in relationship
___ Single, not in relationship
___ Widowed

Please describe relationship (only choose 1)

___ Close
___ Deceased
___ Distant
___ Estranged
___ Supportive
___ Unstable
___ Violent/Abusive

Current relationship length: _____

Number of marriages/domestic partnerships: _____

Previous relationship length: _____

Describe any current family circumstances/issues:

_____

_____

Are there any additional relationship issues or stressors? If yes, please elaborate. _____

_____

_____

Do you have any children? ___ Yes or ___ No If yes, what are their names ages?

Name: _____
Age: _____
Sex: _____
Location: _____

Name: _____
Age: _____
Sex: _____
Location: _____

Name: _____
Age: _____
Sex: _____
Location: _____

Name: _____
Age: _____
Sex: _____
Location: _____

Describe your relationship with children:

_____

_____

Is your family involved in your care: _____Yes or _____No

Describe your family's perception of your illness:

_____

_____

Who do you currently live with?

___ Assisted living
___ Group home
___ Home alone
___ Home with caregiver
___ Homeless
___ Homeless
___ Home with others
___ Jail/Prison
___ Nursing home

Describe current living situation:

_____

_____

Do you identify with any particular religion? _____Yes or _____No If yes, then which one?

_____

Do you have a belief in Higher Power? _____Yes or _____No
If yes, please describe your higher power:

_____

_____

Does spirituality/religion play an important role in your life? _____Yes or _____No

How does your spirituality/religion influence your health?

_____

_____

Do you have any spiritual/religion conflicts?

_____

_____

Describe typical day?

What do you do when you are bored?

Are there any social groups/community organizations to which you belong?

What is the last grade of school you completed? _____

Degree/certifications:

___ None
___ Associates
___ Bachelors
___ GED
___ High School
___ Masters
___ Vocational

Are you currently a student? _____Yes or _____No

If yes, where are you a currently a student? _____

Has there been a change in school performance? _____Yes or _____No

Describe change in school performance:

Describe any learning/behavioral problems:

Describe any recent life transitions.

Are you currently employed? ___ Yes or ___ No

Employer: _____

Job Title: _____

Please describe current occupation and job satisfaction.

_____

_____

Do you have any military history? ___ Yes or ___ No If yes,

What branch(es):_____

How many years? _____

Discharge type? _____

Year of discharge? _____

Have you experienced any abuse? ___ Yes or ___ No

Please check all that apply.
___ Emotional
___ Exploitational
___ Neglect
___ Physical
___ Sexual

What is the timeframe of emotional abuse?
Check all that apply.
___ Current
___ Past 6 months
___ Over lifetime
___ None currently
___ None in past 6 months

What is the timeframe of neglect?
Check all that apply.
___ Current
___ Past 6 months
___ Over lifetime
___ None currently
___ None in past 6 months

What is the timeframe of exploitational abuse?
Check all that apply.
___ Current
___ Past 6 months
___ Over lifetime
___ None currently
___ None in past 6 months

What is the timeframe of physical abuse?
Check all that apply.
___ Current
___ Past 6 months
___ Over lifetime
___ None currently
___ None in past 6 months

What is the timeframe of sexual abuse?
Check all that apply.

___ Current
___ Past 6 months
___ Over lifetime
___ None currently
___ None in past 6 months

Please describe any current/past/or present abuse:

_____

_____

Was the previous abuse ever reported? ___ Yes or ___ No If yes, who was it reported to? _____

_____

Have you experienced psychological trauma? ___ Yes or ___ No

If yes, what kind(s) have you experienced?

___ Bullying
___ Combat
___ Emotional
___ Life threatening disease
___Neglect
___Physical
___Sexual
___ Significant Injury
___ Traumatic family loss
___ Victimization
___ Witness harm to others

Do you have safety concerns for yourself or others? ___ Yes or ___ No
Are these concerns?

___ Current
___ Past 6 months
___ Lifetime
___ None currently
___ None in past 6 months

Please describe safety concerns. _____

Was this concern for safety ever reported? _____

What are your strengths and barriers to recovery?

_____

_____

What are your goals for care, recovery, and discharge?

_____

_____