Optimistic Outlook Counseling

Adult Psychosocial Assessment

1. Client Name: _____ Date: _____
   a. Age: _____ B. Race / Ethnicity: _____ C. Gender: M / F

2. Chief Complaint or Concern: _____
   _____
   _____
   _____

3. Current Medications: Dosage: Frequency: Usage:
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____

4. Medical History:
   a. PCP Name/Location: _____
   b. Psychiatrist Name/Location: _____

5. Are you currently in any physical pain? Yes _____ No _____ If So, where? _____

6. Psychosocial History:
   a. Marital Status and History: *(Include how many and ages)*
      _____
      _____
      _____
      _____
   b. Sexual Preference: (a) Heterosexual, (b) Homosexual, (c) Bisexual
      _____
   c. Education: *(Highest Grade Level Completed)*
      _____

7. Occupational History *(i.e., Performance/Evaluations, Current Job Satisfaction/Dissatisfaction, etc.)*
   a. _____
      _____
      _____
      _____
      _____

8. Any recent loss? _____

9. What is your incentive for change/goal for counseling? _____
   _____
   _____

10. Previous treatment *(Outpatient / Inpatient Services):* _____
    _____
    _____

11. How do you occupy a majority of your time? _____

_____

_____

12. Habits:

Habit	**Frequency**	**Duration**	**Age of Onset**	**Last Use**
Overeating				
Undereating				
Drinking				
Smoking				
Drug Use				
Caffeine				
Diet				
Exercise				

13. Previous history of abuse? (Y or N*) (I.e., Sexual, Physical, Emotional, Domestic Violence, How Long, by Whom?)*

_____

_____

_____

14. Previous history of mental disorders? (Yes / No) If so, whom? _____
15. History of substance abuse? (Yes / No) If so, by whom? _____

_____

_____

16. Family history of suicide? (Yes / No) If so, by whom / how long ago? _____

_____

_____

17. Previous history of self-harm/injury: (Yes / No) If so, when? _____

_____

_____

18. Are you currently having any thoughts of harming yourself or someone else? (Yes / No) _____

_____

_____

19. Any previous suicide attempts in the past? (Yes / No) If yes, please explain: _____

_____

20. List previous arrest: *(Include offense & year)*

_____

_____

Regulation: → **Mood:** neutral / happy / sad / fearful / anxious / hostile / angry / silly / irritable / crying / other

Changes in Mood: Irritability: _____ Decreased Concentration: _____ Mood Swings:_____ Guilt: _____

Loss of Interest in Activities: _____ Low Self-Esteem: _____ Hopelessness:_____ Helplessness: _____

Frustration Tolerance and Anger Management Skills: frequent temper tantrums /outbursts/ severe lack of anger management results in aggression ___ or assaultive behaviors___ Comments: _____

_____

Cognition/Thought Processes:

Hallucinations: no current hallucinations / auditory / visual / tactile / olfactory / reacting to internal stimuli
Delusions: no current delusions / over-valued ideas
Thought Processes: goal directed / logical / obsessive / unusual fears/ flight of ideas / illogical
Insight: good / fair / inconsistent / poor
Judgment: good / fair / inconsistent / poor
Intelligence: average / above average / borderline / below average / other
Comments: _____
Unusual Behaviors: not applicable / compulsions / sexual acting out / traumatic reenactments/ head banging / spinning, twirling / hand flapping / finger flicking / rocking, toe walking / staring at lights / spinning objects / repetitive / preservative / bizarre verbalizations / hair pulling / ruminating / holding breath / other Comments: _____

_____

Sleep Patterns: disrupted nighttime sleep / sleeps in the day (not including age appropriate napping) / difficulty falling asleep / difficult to arouse after sleep / frequent night terrors / frequent nightmares / other Comments: _____

_____

Eating Patterns: very selective / very limited range of foods / not eating enough resulting in weight loss / overeating / binging / purging / refusing to eat / other Comments: _____

_____

Stop here. → *K. Flucas ~ Counselor Notes Below:*

Counselor Notes:

_____

_____

_____

DSM Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Client Signature _____ Date: _____

Counselor Signature _____ Date: _____