Psychosocial Assessment

Name_____ DOB_____

Mother's Name:_____

Father's Name_____

PRESENTING PROBLEM: What brings you here today?

_____

_____

Mental Health History

Please circle all that apply to you (choose severity that applies):

(0) Not Present, (1) Mild, (2) Moderate, or (3) Severe)

Depression	0 1 2 3	Memory Problems	0 1 2 3	Panic Attacks	0 1 2 3
Anxiety	0 1 2 3	Loss of Interest	0 1 2 3	Obsessive Thoughts	0 1 2 3
Mood Swings	0 1 2 3	Irritability	0 1 2 3	Ritualistic Behavior	0 1 2 3
Appetite Changes	0 1 2 3	Excessive Worry	0 1 2 3	Checking	0 1 2 3
Sleep Changes	0 1 2 3	Suicidal Ideation	0 1 2 3	Counting	0 1 2 3
Hallucinations	0 1 2 3	Relationship Issues	0 1 2 3	Self-Injury	0 1 2 3
Racing Thoughts	0 1 2 3	Low Energy	0 1 2 3	Difficulty with Concentration	0 1 2 3
Confusion	0 1 2 3	Hyperactivity	0 1 2 3		

Describe a brief history of your present symptoms:

_____

_____

What effect have they had on your life?

_____

_____

Have you ever been treated for a mental health problem? If yes, please describe:

_____

_____

Have you ever had a mental health hospitalization? ___No ___ Yes, please describe:

_____