

Adult Psychosocial Evaluation

Name _____ BirthDate _____ Referred by: _____

Presenting Problem/Concerns:

onset/precipitating event:

methods of coping tried/ results:

Previous history of therapy (in or out of school) (why and how it stopped) (hospitalizations/ suicide attempts):

Family Mental Health History (family/friend suicide ?) (Alcohol/ Drug Use - risky situations or family/ friends concerned?, Physical fighting in the family/ financial control, physical or sexual abuse, neglect or verbal abuse, violent tempers, homicide, arrests or court dates):

Medications: Name, dosage, purpose, prescribing physician

Current Functioning:

Eating:

Sleeping:

Smoking:

Name _____

Employer/ Job history / School/ Highest Level achieved:

Hobbies/ Interests:

Peers/ Support/ Social life/ Religion/ Spirituality:

Sex Life/ Sexual Identity/ Gender identity/ Pronouns:

Screen time (Social Media) per day (not work related):

Family Composition: (Names, ages, jobs, marriages, divorces and schedule, siblings, child care, relationships, parent's relationship):



Chronology of Major Life Events: (Losses/ Separations/ Car accidents/ Surgeries or Hospital visits/ Medications - was caregiver present?)



Name _____

What stands out about early development / any disruptions in early caregiving (prison/ Foster care/ Rehab):

Problem Formulation: _____

Jennifer Brown, L.C.S.W.

Date

Additional Notes: Goals/ How long anticipate therapy taking?/ What are your strengths?