GLIO COUNSELING GROUP, PLC
PSYCHOSOCIAL ASSESSMENT

GENERAL INFORMATION:

Date: _____________ Client: ____ ☐ M ☐ F

Age: _______ Date of Birth: ________________ With Whom do you live? _______________________

Why are you seeking treatment at this time? ____

FAMILY HISTORY:

Who were you raised by (check all that apply): ☐ Biological Mother ☐ Biological Father

☐ Stepmother ☐ Stepfather ☐ Other: ____

Is there a history of mental illness in the family? ☐ Yes ☐ No If yes, who and what kind

of illness? ____

Have any family member committed suicide? ☐ No ☐ Yes, Who? __________________Year? _______

Is there a history of drug and/or alcohol problems in the family? ☐ No ☐ Yes

Who? ___________________________ What substance? _____________________________________

Did you witness or experience any physical or emotional abuse? If yes, please explain:

____

Have you ever been sexually abused? ☐ No ☐ Yes If yes, please explain: _______________________

Please describe the family in which you were raised: ____

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

CULTURAL & RELIGION:

Do you identify with a particular ethnic group? ☐ No ☐ Yes (please name): __________________

Do you identify with a particular religious group? ☐ No ☐ Yes, which one? ____________________

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

MARRIAGE AND PARTNERSHIP

Present Relationship Status: ☐ Never Married ☐ Married/Living Together _____ years

☐ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐ Boyfriend ☐ Girlfriend ☐ Single

Are you currently or have you experienced any physical, emotional, or sexual abuse in your relationships? If yes, please explain: ____

Has your significant other ever struggled or currently struggles with emotional condition? ☐ Yes ☐ No

Has your significant other ever struggled or currently struggles with a drug or alcohol problem?

☐ No ☐ Yes (please explain): ____

How many children do you have? ____ Their Ages: __________________

Previous marriages/relationships:

Dates: _______________ Description: _________________________ # of children: __________

Dates: ________________ Description: _________________________ # of children: ___________

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

EDUCATION HISTORY:

What is the highest level of education completed? _______ What type of grades did you obtain? ______

Any Learning Disabilities? ☐ No ☐ Yes (please explain): ____

Check all that apply regarding your school experience: ☐ gifted classes ☐ special education

☐ School suspensions ☐ problems with classmates/teachers

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

EMPLOYMENT HISTORY: ☐ Not Applicable (child)

Did you ever serve in the U.S. Military? ☐ No ☐ Yes. Discharge status? _________________________

Did you ever serve in combat? ☐ No ☐ Yes Are you currently employed? ☐ No ☐ Yes

What is your occupation? ___________________ Have you ever been fired from a job? ☐ No ☐ Yes (why?) ____

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

MEDICAL HISTORY

What medical issues do you currently have? ____

How do you rate your general health? ☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent

What medications are you currently taking? ____

Please explain if you have had any head injuries or loss of consciousness: _________________________

Do you have difficulty sleeping? ☐ No ☐ Yes (please describe): _____________________________

Do you have nightmares/night terrors? ☐ Yes ☐ No

Do you have any changes in eating habits/appetite? ☐ Yes ☐ No Any recent weight loss/gain? ☐ No ☐ Yes

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

PSYCHIATRIC HISTORY

Have you ever been hospitalized for psychiatric reasons? ☐ No ☐ Yes (where?) ___________________

Have you been in counseling before? ☐ No ☐ Yes If yes, what type and when? ________________

Please check categories you are having difficulties in:

☐ Depression ☐ Thoughts of Homicide ☐ Thoughts of Suicide

☐ Anxiety ☐ Sudden Mood Changes ☐ Overly Dependent

☐ Anger Control Problems ☐ Hallucinations (hearing voices or seeing things)

☐ Not liking self ☐ Withdrawal from others ☐ Overly Suspicious

☐ Problems with: ☐ Spouse ☐ Children ☐ Friends

Please check any additional categories in which you are having difficulty in:

☐ Suicide Attempts ☐ Obsessions or Compulsions ☐ Serious Trauma ☐ Self-Abusive Behaviors

Please Explain: _______________________________________

Psychiatric Assessment/Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

LEGAL HISTORY:

Were you ever arrested, convicted or placed on probation as a juvenile? ☐ No ☐ Yes

If yes, age? _______________ Offense: _________________________________

Were you ever arrested or convicted as an adult? ☐ No ☐ Yes

If yes, age? _______________ Offense: _________________________________

Are you currently on probation/Parole? ☐ No ☐ Yes (describe) __________________________________

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

SUBSTANCE ABUSE HISTORY: ☐ Not Applicable. No history of drug/alcohol use

Check all that apply regarding your drug/alcohol history:

☐ Alcohol	____years of use	_____Last date used	_____frequency of use
☐ Cocaine/Crack	____years of use	_____Last date used	_____frequency of use
☐ Marijuana	____years of use	_____Last date used	_____frequency of use
☐ Heroin	____years of use	_____Last date used	_____frequency of use
☐ Prescription Drugs	____years of use	_____Last date used	_____frequency of use

☐ Hallucinogens ☐ Methadone ☐ Uppers/Downers ☐ Other (inhalants, glue, cigarettes, etc.)

____years of use _____Last date used _____frequency of use

What is your substance of **preference?** ____

Have you received treatment for a substance abuse problem before? ☐ No ☐ Yes (where?) __________

What type of service did you receive? ☐ Outpatient ☐ Inpatient ☐ Detox ☐ Other: _______________

Is there anything not addressed on this assessment that you want your therapist to know? ☐ NO ☐ YES

If yes, please list: ____

____

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

_____________________________________ ___________________

Client Signature Date

CLINICIAN USE ONLY

GLIO COUNSELING GROUP PLC

MENTAL STATUS:

MOOD:	DEPRESSED	EUTHYMIC	ELATED	ANXIOUS	IRRITABLE
AFFECT:	APPROPRIATE	INAPPROPRIATE	______________________		
ACTIVITY:	NORMAL	HYPERACTIVE	HYPOACTIVE	RESTLESS	
THINKING:	NORMAL	ORGANIZED	DISORGANIZED	EVASIVENESS	
ORIENTATION:	NORMAL	CONFUSED			
PERCEPTION:	NORMAL	IMPAIRED	ILLUSIONS	HALLUCINATIONS	

PRESENTING ISSUES:

DIAGNOSTIC IMPRESSION

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V:

TX GOALS:

CLINICIAN'S SIGNATURE ____ DATE _____________________