

## Psychosocial Inventory

Please complete the following information regarding prior to your first appointment and bring it with you to the session. Completing this form in advance will help the assessment process go more quickly. During the initial session, we will review the provided information together. You may complete this form by typing in the fields provided or by printing and completing by hand. If you are unsure of an answer or feel that a question does not apply, you may leave it blank. All information will be kept confidential.

For couples, please each complete a separate inventory to provide your information.

Date:

Form completed by:

Client Name:

Gender:

Date of birth:

Age:

Race/Ethnicity:

Address:

Phone:

Referred by:

### **Presenting Problem:**

What is the main concern that brings you to therapy?

How long has this been a concern?

What have you already tried to address the problem? Has anything been helpful so far?

What do you hope to get from therapy?

Have you had any changes or problems with your sleep, appetite, or hygiene? (Please describe)

Do you have any history of trauma or upsetting life events (such as abuse, life threatening accidents or medical concerns, family conflict, bullying, divorce, death or loss of loved ones, or natural disasters)?

Yes  No (If yes, please describe.)

Has you ever had psychotherapy or counseling before?  Yes  No (If yes, please describe.)

Have you been given a previous psychological diagnosis?  Yes  No (If yes, please describe.)

Are you currently taking any medications for emotional or behavioral reasons?  Yes  No

If yes, please list name of medication, dosage, and reason prescribed.

Have you taken any other medications in the past for emotional or behavioral reasons?  Yes  No

If yes, please list name of medication, dosage, and reason prescribed.

Have you ever been hospitalized for emotional or behavioral concerns?  Yes  No

If yes, please describe reason and provide name of hospital.

Have you ever had suicidal thoughts, made suicide attempts, or self-harmed (including cutting)?

Yes  No (If yes, please describe.)

Do you use drugs or alcohol?  Yes  No (If yes, please describe.)

Do you feel that your use of drugs or alcohol is problematic?  Yes  No (If yes, please describe.)

Has anyone ever suggested that you should decrease your use of drugs or alcohol?  Yes  No  
(If yes, please describe.)

### **Medical History:**

Primary Care Doctor:

Doctor's phone number:

Date of last physical exam:

Do you have any allergies?  Yes  No (If yes, please describe.)

Please describe any past and present medical concerns or serious illnesses:

Please list any current medications and reason for taking:

Have you ever been hospitalized for medical reasons or had surgery?  Yes  No  
(If yes, please describe.)

Do you have any problems with vision, hearing, or dental health?  Yes  No  
(If yes, please describe.)

### **Family Information:**

Please list family members that live in your home, including names and ages:

Other close family members that live outside of the home (e.g., children):

Relationship status:  Married  Single  Engaged  Divorced  
 Living together  Partnered, living separate  Separated  Divorced  Widowed

Are there family members or others that you consider part of your support system? Please describe.

Religious/spiritual identification:

Do you actively participate in religion/spirituality?  Yes  No

Do you consider religion/spirituality to be a source of support?  Yes  No

Please describe your family of origin (e.g., parents, siblings, support system, significant childhood events) and current relationship with members of family of origin:

Do you have any concerns related to family relationships/interactions, parenting/discipline, or family communication?  Yes  No (If yes, please describe.)

**Vocational Information:**

Current occupation:

Place of employment:

Do you have any concerns related to your work, such as relationship conflicts, difficulties that interfere with your work, or frequent loss of job?  Yes  No (If yes, please describe.)

Level of education:

Do you have any history of difficulties with school, such as learning disorder or behavioral?  Yes  No (If yes, please describe.)

**Additional Information:**

How would you describe your personality in a few words?

What are some of your strengths and positive qualities?

Is there any other information that I should know?