INSIDEOUT DYNAMICS, Inc.
PSYCHOSOCIAL ASSESSMENT

Name: _________________________________________________________ Age: _____ Sex: _____
Therapist: ___________________________________________________________________________

DIRECTIONS: Please answer the following questions as fully as possible.

Problem Assessment
Present problem - “In recent months, I have worried a lot about…
Please circle all that apply:

- Marital Issues
- Health Issues
- Job Issues
- Financial Issues
- Parent/Child issues
- Issues from the past (guilt, abuse, neglect, family of origin issues, etc.)
- Other ____________________________________________________________________________

Symptoms: Please circle all that apply:

- Change in sleep patterns
- Decreased concentration
- Change in appetite
- Increased anxiety
- Decreased energy
- Suicidal feelings
- Decreased motivation
- Other ____________________________________________________________________________

Suicidal/Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? □ yes □ no If yes, how?
_________________________________________________________________________________

Is there a history of suicide in your nuclear and/or extended family? □ yes □ no
Have you ever inflicted burns or wounds to yourself? □ yes □ no
Are you presently suicidal/homicidal? □ yes □ no

What event(s) in the recent past has/have prompted you to seek counseling? ______________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Describe additional problems you are experiencing.
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

When did these problems develop?
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Circle any losses you have experienced.

- Family
- Health
- Disruption of lifestyle
- Job
- Significant other
- Other ____________________________________________________________________________
List your strengths and weaknesses.

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<th>Strengths</th>
<th>Weaknesses</th>
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**Psychiatric History**
Please list any previous outpatient counseling experiences.
Place ______________________________________________________________
Length of time there ______________________________ Dates ______________________________
Have you ever been admitted to the hospital for mental health or addiction issues?
Place ______________________________________________________________
Length of time there ______________________________ Dates ______________________________
Name of current doctor and/or therapist ___________________________________________________
List all medications you have taken in the past for anxiety, depression, and/or sleep. __________

**Medical Information:**
How would you describe your current condition of health? _____________________________________________
Are you currently on any medication? □ yes □ no
Name of medication __________________________ Dosage/Frequency __________________________ Prescribing Physician __________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
Has it been more than a year since your last physical exam including blood test? □ yes □ no
Have you ever had an abortion? □ yes □ no
Do you have allergies? □ yes □ no If yes, explain _______________________________________
List any previous health problems, operative procedures, and medical hospitalizations:

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<th>Problem</th>
<th>Dates</th>
<th>Treatment</th>
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**Substance Abuse History**
Describe your current usage or usage within the past year (including alcohol, caffeine and tobacco).

<table>
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<th>Substance</th>
<th>Amount</th>
<th>Frequency</th>
<th>Age of 1st use</th>
<th>Age regular use started</th>
<th>Last use</th>
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Have you experienced a recent increase in the use of alcohol and/or other substances? □ yes □ no
Do you see your current usage as a problem? □ yes □ no If yes, when did it become problematic?____
Please describe any previous experience with drugs or alcohol.

____________________________________________________________________________________

Describe any significant family history of substance abuse.

____________________________________________________________________________________

Nutrition:
Have your eating habits changed recently? □ yes □ no  If yes, please describe

____________________________________________________________________________________

Has your weight fluctuated more than +/- 10 lbs. over the previous year? □ yes □ no

Do you often eat out of depression, boredom, anger? □ yes □ no  If so, please describe

____________________________________________________________________________________

Do you ever self-induce vomiting? □ yes □ no

How do you feel about eating with others in a group?

Do you ever binge eat or feel your eating is out of control? □ yes □ no  If yes, please describe

____________________________________________________________________________________

If you use laxatives, water pills (diuretics), or diet medications, how often do you use them?

____________________________________________________________________________________

Legal History:
Please explain all that apply:

Charges as a minor

Charges presently

Arrests (how many)

Incarcerations (how many)

Parole

Convictions (how many)

Probation

Bankruptcy

Civil Suits

Child Custody Problems

Development History:
List members of your family of origin and how you get along with each one.

Family Member  Comment

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

What was your birth order? ______ of ______ children  Who primarily raised you ?

How would you describe your childhood? □ Traumatic  □ Painful  □ Uneventful
What were you like as a child (include friends, school, hobbies, and personality)?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Were there any unusual or traumatic experiences for you as a child?

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<th>Date</th>
<th>Age</th>
<th>Event</th>
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Living Arrangements:  □ Satisfactory  □ Unsatisfactory

Where do you currently live? ________________________________ For how long? ______________

With whom are you living? ________________________________

Describe your current relationships with family members.

____________________________________________________________________________________

Support System:

Who can you count on for support?  *Circle as many as apply:*

Parents  Spouse  Siblings  Employer  Church  Co-Worker  Therapist
Neighbor(s)

Extended Family  Close Friend  Self-help Group  Community Services  Pastor  Medical Doctor

Other ________________________________

Financial Situation:

Describe briefly your financial situation.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Martial History (if applicable):

When were you married? ______________ Name and age of spouse __________________________

Previous marriage □ yes □ no  If yes, date of divorce __________________________

Any children from this marriage? ________________________________
What is your perception of your current marriage (include communication patterns, problems, sexual relations).
________________________________________________________________________ _______________
________________________________________________________________________ _______________

List names and ages of children.

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<th>Comment</th>
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How do you get along with each one?

Religious/ Cultural Factors:
Please list issues which are important or may have affected you in regard to religion / cultural background.
____________________________________________________________________________________
___________________________________________________________________________________
______________________________________________________________________________

What is your religious background?

Do you currently attend church, synagogue, or mosque? □ yes □ no

Work Adjustment History:
Describe your current job/career _________________________________________________________
______________________________________________________________________________

What do you like/dislike about your employment/career? Please list:

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<th>Dislike</th>
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Would you enjoy doing this job on a long-term basis? _________________________________
If you could have any job/career, what would you choose? ________________________________
   Why would you choose this?

How do you deal with authority figures? _____________________________________________
Describe your relationship with co-workers ____________________________________________
Describe your job performance _______________________________________________________

Have you ever been fired? □ yes □ no   If yes, explain __________________________________

How many jobs have you held within the previous five years? ____________________________
Military History:
List branch, dates, and duties. __________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Educational History:
What was school like for you?
Highest level achieved? ___________ What type of grades did you make?_______________________
Currently in school? □ yes □ no If yes, what level? _______________________________________

Family:
Would it be beneficial for any members of your family to be involved in your treatment? □ yes □ no
If yes, explain who and why. ___________________________________________________________

Miscellaneous:
Are there any other things that can be helpful for us to know about you? ______________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Signature ___________________________________________ Date _____________________________