Free Psychosocial Assessment Form

Client Information:

- Name: _____
- Date of Birth: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Phone Number: _____
- Email: _____

Referral Information:

- Referred By: _____
- Date of Referral: _____
- Reason for Referral: _____

_____

Presenting Problem:

- Description: _____

_____

Psychosocial History:

- Family Background: _____

_____

- Education/Employment: _____

_____

- Substance Use: _____

_____

Medical History:

- **Current Medications:** _____

_____

- **Allergies:** _____

_____

Mental Health History:

- **Previous Diagnoses:** _____

_____

- **Treatment History:** _____

_____

Assessment Summary:

_____

_____

Clinician Signature:

- **Clinician Name:** _____
- **Clinician Signature:** _____
- **Date:** _____