Psychosocial Assessment PDF

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: _____