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Adult Outpatient Diagnostic Assessment
Psychosocial Self-Assessment (To be completed by client)

Name: _____
Date of Birth:_____ Age:_____ Gender:_____
Race: _____
Referral Source: Self ☐ Physician (name)_____ other _____

Reasons For Seeking Treatment:
I am seeking treatment at this time because:

_____
_____
_____
_____

I have been having problems like this since_____

My family/others want me to seek treatment because:

_____
_____
_____
_____

Family History:
Current marital status of my parents:
☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single Parent
My father's age, if living _____
His occupation _____ His highest education _____
His health status _____
If deceased, his age at death and cause of death _____
Your age when he died _____

Any history or mental illness or addictions in my father:

_____
_____
_____

My mother's age, if living _____
Her occupation _____ Her highest education _____

Her health status _____

If deceased, her age at death and cause of death

_____

_____

_____

Your age when she died _____

Any history of any mental illness or addictions in my mother

_____

_____

_____

My siblings:

Brother/Sister	Age	Occupation	History of Mental Illness/Addictions
1. _____			☐ Yes ☐ No
2. _____			☐ Yes ☐ No
3. _____			☐ Yes ☐ No
4. _____			☐ Yes ☐ No

Do you have stepparents? ☐ Yes ☐ No

If yes, rate your current relationship with them

☐ tense ☐ close ☐ no contact at all

☐ very close ☐ distant ☐ other_____

Rate your current relationship with your biological parents:

☐ tense ☐ close ☐ no contact at all

☐ very close ☐ distant ☐ other _____

Rate your current relationship with your siblings:

☐ tense ☐ close ☐ no contact at all

☐ very close ☐ distant ☐ other _____

Rate your current relationship with your extended family:

☐ tense ☐ close ☐ no contact at all

☐ very close ☐ distant ☐ other _____

List any other family members who may have a history of mental illness or addiction:

Relationship to me Type of problem

_____

_____

_____

Childhood Memories:

I was born in _____ I was reared in _____

Family's socioeconomic status: ☐ high ☐ medium ☐ low

Stability of home ☐ very stable ☐ not too stable ☐ unstable

My primary caretaker ☐ mother ☐ father ☐ siblings ☐ grandparents

☐ aunt/uncle ☐ other _____

Describe any positive or negative memories that you have about your childhood including physical or emotional abuse:

Developmental History:

To my knowledge, I had a normal birth, delivery, and normal early childhood development (that is, I walked, talked, etc., about on time). ☐ Yes ☐ No

If no, please explain:

Education:

I completed the _____ grade, or _____ years of college with a degree in _____

Did you like school? ☐ Yes ☐ No ☐ Somewhat

Did you get good grades? ☐ Yes ☐ No ☐ Somewhat

What were (are) your strengths and weaknesses in school?

Strengths_____

Weaknesses_____

If currently in school, which school? _____

Any grade failures? _____

Were you ever diagnosed with a learning disability? ☐ Yes ☐ No

Were you ever diagnosed with attention deficit disorder or hyperactivity ☐ Yes ☐ No

Any history of behavior problems, i.e., suspensions, truancy, fighting? ☐ Yes ☐ No

If yes, please explain

Employment:

I am employed ☐ Yes ☐ No

I am employed with _____

My job title is _____ Years Employed _____

Summaries Employment History _____

Is your employer aware of a need for treatment? ☐ Yes ☐ No

If yes, does your employer have any special requirements for you to return to work?

☐ Yes ☐ No

Finances:

Do you have a problem with managing money? ☐ Yes ☐ No

Are you currently experiencing financial distress? ☐ Yes ☐ No

Please comment

Social/Leisure:

Leisure activities I enjoy, and how often I participate in them:

Type How often

_____

_____

_____

My level of interest in these activities has changed lately: ☐ Yes ☐ No

How are these changes and your problem related? _____

_____

I have enough close friends who provide me with support. ☐ Yes ☐ No

Please comment _____

_____

Sexual History:

My sexual orientation is: ☐ heterosexual ☐ bisexual ☐ homosexual

Age of first sexual experience _____

Any sexual abuse or trauma (either as a victim or a perpetrator) as a child or as an adult:

☐ Yes ☐ No

If yes, please explain _____

_____

Has your interest in sex changed lately? ☐ Yes ☐ No

If yes, please explain _____

_____

Marital Information:

Marital status: ☐ Married ☐ Single, never married ☐ Divorced ☐ Widowed

Spouse's name: _____ Age, if living _____ Occupation _____

Health status: _____

If deceased, age at death and cause of death _____

Years married _____

Relationship with spouse: ☐ Satisfactory ☐ Unsatisfactory ☐ Needs Improvement

Please comment _____

My spouse has a history of mental illness: ☐ Yes ☐ No

My spouse has a history of addiction: ☐ Yes ☐ No

If previously married, state how long you were married, and reason relationship ended:

How long married Reason for ending

_____

_____

_____

My children and step-children from all relationships:

Name M/F Age Relationship with me Comments

_____ ☐ Satisfactory ☐ Unsatisfactory _____

_____ ☐ Satisfactory ☐ Unsatisfactory _____

_____ ☐ Satisfactory ☐ Unsatisfactory _____

_____ ☐ Satisfactory ☐ Unsatisfactory _____

_____ ☐ Satisfactory ☐ Unsatisfactory _____

_____ ☐ Satisfactory ☐ Unsatisfactory _____

Living Situation:
I currently live with _____
Other people living in my house (if any) are _____
_____
I live in a ☐ House ☐ Apartment ☐ Trailer that I ☐ Own ☐ Rent
If other living accommodations are used, please describe: _____

Military History:
Branch of service: _____ Number of years served: _____
Rank at discharge: _____
Type of discharge: ☐ Honorable ☐ Dishonorable ☐ Medical ☐ Other _____
Comments on your time of service, including promotions, demotions, problems, successes, etc.:
_____
_____

Cultural/Religious:
In what religion, if any, were you raised? _____
Are you currently active in any religion? ☐ Yes ☐ No
If yes, please comment _____
_____

How has your cultural/ethnic/religious heritage or background affected you or your family?
_____
_____
Describe your spiritual orientation _____
_____
Describe what gives meaning to your life _____
_____

Legal History:
Do you have an arrest record (including DUIs)? ☐ Yes ☐ No
If yes, please explain:
Date Type of offense Result
_____
_____
_____
Any other legal involvement (pending suits, bankruptcy, divorce, custody issues)?
☐ Yes ☐ No
If yes, please explain _____
_____

Psychiatric:
I have problems with depression: ☐ Yes ☐ No
I have problems with anxiety: ☐ Yes ☐ No
Describe any other problems: _____
Previous inpatient or outpatient treatment: ☐ Yes ☐ No
Dates Where Treatment/Medications Prescribed
_____
_____
_____

Alcohol and Drug History:

I have drank alcohol: ☐ Yes ☐ No
I first drank alcohol at age: _____.
I last drank alcohol: (date) _____.
I typically drink alcohol: ☐ 1-2 times per month, ☐ 1 time per week, ☐ 2-3 times per week, ☐ 4-6 times per week, ☐ daily
When I drink, I usually have: ☐ 1 drink, ☐ 2-3 drinks, ☐ 4-5 drinks, ☐ 6-10 drinks, ☐ 10+ drinks
I have used tobacco products: ☐ Yes ☐ No
I first used tobacco at age: _____.
I last used tobacco: (date) _____.
I typically use tobacco: ☐ 1 time per week, ☐ 2-3 times per week, ☐ 4-6 times per week, ☐ daily
I have used marijuana: ☐ Yes ☐ No
I first used marijuana at age: _____.
I last used marijuana: (date) _____.
I typically use marijuana: ☐ 1 time per month, ☐ weekly, ☐ several days per week, ☐ daily

Please list other drugs used:

Name of Drug	Age First Used	Last Used	Frequency of Use

I use caffeine: ☐ Yes ☐ No
I consume the following caffeinated foods/drinks: ☐ coffee, ☐ soda, ☐ tea, ☐ chocolate
How many of cups of caffeinated drinks do you consume in a day? _____

My drinking and/or drug use has had an effect on the following life areas:
☐ Family ☐ Social ☐ Legal ☐ Job ☐ Physical ☐ Financial ☐ Emotional

Previous inpatient or outpatient treatment for drugs and/or alcohol: ☐ Yes ☐ No

Dates	Where	Treatment/Medications Prescribed

Any involvement in AA, NA, support groups, etc? _____

Self-Assessment:

I see my personal strengths and weaknesses as:

Strengths	Weaknesses

Trauma:

Any abuse (verbal, physical, or sexual)? When? By Whom? _____
Any natural disasters (fire, tornado, earthquake, etc.)? When? _____
Any deaths or major losses? When? _____
Any other trauma? When? _____

Medical:

Any chronic/current medical problems? ☐ Yes ☐ No

If yes, please explain _____

Any allergies? ☐ Yes ☐ No

If yes, please explain _____

Any surgeries? ☐ Yes ☐ No

I am currently taking the following medications: _____

Date of last physical examination, doctor's name, and the results of the examination:

_____ _____

Client's Signature Date