



# PSYCHIATRIC & ADDICTION SERVICES

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## Psychosocial Assessment Form

Date: \_\_\_\_\_ ID #: (office use only) \_\_\_\_\_

### Patient Information

Patient Name: _____	Gender: _____	MALE	FEMALE
Race: _____	Marital Status: _____		
Home Address: _____	Telephone Number: _____		
Place of Birth: _____	Date of Birth: _____		
Number/Length of Marriages: _____	Children/Ages/Parents with whom they reside: _____		

History of Problem (difficulties with emotional, behavioral, professional or social life):  
\_\_\_\_\_

Legal History (past & current):  
\_\_\_\_\_

Education History/Degrees:  
\_\_\_\_\_

Traumatic Events (childhood, adolescence and adulthood):  
\_\_\_\_\_

Employment History (current, positive/negative experiences, history and goals):  
\_\_\_\_\_

Medical History (chronic illness, surgeries, hospitalizations):  
\_\_\_\_\_

Ethnic/Cultural/Religious Factors (spiritual orientation, influence on identity, values and beliefs):  
\_\_\_\_\_

Family History (significant others, parents & siblings-names, ages & place of residence):  
\_\_\_\_\_

Family Medical History (emotional problems, mental illness, substance abuse, medical problems or psychotropic medications):  
\_\_\_\_\_

Alcohol/Drug Use:  
\_\_\_\_\_