E-Motional Change Therapy
PSYCHOSOCIAL ASSESSMENT

Date: ______________________ Therapist: ______________________

Client: ______________________ Client's DOB: ______________________

Referred by: ______________________ Relationship to Client: ______________________

Reason for coming in:

Personal and Family History:

Raised by: □ biological parent(s) □ adoptive parent(s) □ grandparent(s) □ other: ______________

Siblings: Name	DOB	Describe Relationship
______________	________	______________________
______________	________	______________________
______________	________	______________________
______________	________	______________________

Sexual Orientation: □ heterosexual □ homosexual □ bisexual □ transsexual □ transgender □ questioning
Relational Status: □ single □ living together/married/partnered □ separated/divorced □ widowed

Children: Name	DOB	Describe Relationship
______________	________	______________________
______________	________	______________________
______________	________	______________________
______________	________	______________________

Any history of physical, sexual or emotional abuse:

Other relevant family factors:

Social, Cultural and Religious Factors: include significant friendships & community involvement.

Education, Employment and/or Military Service History:
Highest level of education: □ elementary □ middle school □ high school □ college □ graduate

Learning Disabilities?: ADHD?:

Head Injuries?:

School/Work/Military History:

Medical History: General Health: □ excellent □ good □ fair □ poor

Medications: Name	Dosage	Taking since	Prescribed by
______________________	__________	__________	________________
______________________	__________	__________	________________
______________________	__________	__________	________________
______________________	__________	__________	________________

Smoke?: _____ cigarettes/day

Drink?: how much/how often?:____

Drug use?: Substance? how much/how often? _____________________________

Hospitalization(s):

Dates from-to	Reason	Outcome
________________	______________________	______________________
________________	______________________	______________________
________________	______________________	______________________

Relevant Family Medical History:

Legal History:

Shaded area to be filled out by clinician

Mini Mental Status Exam:

Oriented to: □ person □ place □ time □ situation

Mood: Affect:

Dress & Grooming: Speech & Cognition:

Sui Ideation: YES NO Homi Ideation: YES NO

If yes to either of above, describe any early interventions:

DSM IV- Diagnostic Codes:

Axis I:

Axis II: GAF= Past

Axis III:

Axis IV:

Axis V: GAF= Current

Goals for Therapy:

1.
2.
3.
4.