Greenfields Counseling and Consulting

Brief Psychosocial Assessment

Name:_____
Date:_____

Address:_____

Date of Birth:_____ Phone numbers:_____

Referred by: _____
_____

I. Reason for Visit:_____

Date of onset: -
_____

Goals for treatment:_____

_____

II. Previous Treatment/ Therapeutic Growth Experiences:

_____
_____

III. Relationship status:_____ Number of Children:_____
Age of Children: _____

Environment in your childhood home:
_____

_____

_____

IV. Employment/Vocational/experiences:

_____

_____

Education level:_____

V. Legal History: _____

_____

VI. Medical History:_____

Surgeries:_____

Accidents/Injuries:_____

Greenfields continued

_____

_____

General Diet:_____

Allergies:_____

Medications:_____

_____

Psychiatrist:_____
Physician:_____
Additional Information:_____

_____

VII. What is your current status spiritually?_____

_____

VIII. What do you consider your strengths?_____

_____

Weaknesses:_____

_____

IX. Ever had negative consequences as a result of using substances?_____

_____

_____

Alcohol Intake:_____
Tobacco:_____

X. Leisure Activities:_____

_____

XI. Expectations for yourself with Counseling or Consulting:_____

_____

_____

_____

I know my work has been successful when:_____

_____

Date:_____ Time:_____ Location:_____