

# PSYCHOSOCIAL INVENTORY

**Information Given Below is For Counseling Purposes Only**

The information supplied below is for the use of your counselor and will be kept confidential. Please help your counselor by answering each question as fully and honestly as you can. If you are a parent/guardian who is helping to complete this document for your child/adolescent, please note that the counselor may ask you to step out during certain portions of this questionnaire.

## PERSONAL IDENTIFICATION DATA

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Parent(s)' Name(s) (for a child/adolescent): \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Gender: \_\_\_\_\_ Birthday: \_\_\_\_\_ Age: \_\_\_\_\_

Primary racial/cultural background:

Asian                       Black/African American     Caucasian                       Native American

Hispanic/Latino             Biracial/bicultural                       Other: \_\_\_\_\_

Referred for counseling by: \_\_\_\_\_

## BRIEFLY ANSWER THE FOLLOWING QUESTIONS (use the back of this page if necessary)

1. What is the main problem, as you see it (what brings you here)?

\_\_\_\_\_

\_\_\_\_\_

2. What have you done about it up to this point?

\_\_\_\_\_

\_\_\_\_\_

3. What do you want us to do (what are your expectations in coming here)?

\_\_\_\_\_

\_\_\_\_\_

4. Is there any information we should know at the outset of counseling?

\_\_\_\_\_

\_\_\_\_\_

## PERSONALITY INFORMATION

Circle any of the following words which you feel best describe you:

active ambitious self-confident persistent nervous hardworking impatient impulsive moody  
excitable imaginative calm serious easygoing shy good-natured introvert often-blue extrovert  
likeable leader quiet hard-boiled submissive self-conscious lonely sensitive passive indifferent

Pick 3-5 words that others would use to describe you (list here): \_\_\_\_\_

\_\_\_\_\_

**HEALTH INFORMATION**

**Physical Health**

Rate your physical health: \_\_\_ Very Good \_\_\_ Good \_\_\_ Average \_\_\_ Declining \_\_\_ Other (please explain below):

Recent weight changes: Lost \_\_\_\_\_ Gained \_\_\_\_\_

List all important present or past illnesses, injuries, or handicaps: \_\_\_\_\_

Date of last medical examination: \_\_\_\_\_ Results of examination: \_\_\_\_\_

Your physician: \_\_\_\_\_ Contact Info: \_\_\_\_\_

Have you used drugs for other than medical purposes? \_\_\_ Yes \_\_\_ No (If yes, please describe) \_\_\_\_\_

Are you presently taking any medication(s) for physical reasons? \_\_\_ Yes \_\_\_ No (If yes, please describe) \_\_\_\_\_

What positive things do you do that impact your physical health (e.g., exercise, eat nutritious meals, take vitamins, etc.)? \_\_\_\_\_

**Emotional Health**

Have you ever had a severe emotional upset? \_\_\_ Yes \_\_\_ No (If yes, please explain) \_\_\_\_\_

Have you ever had any psychotherapy or counseling? \_\_\_ Yes \_\_\_ No (If yes, list counselor(s)/location(s) and date(s)) \_\_\_\_\_

What was the outcome of any prior counseling? \_\_\_\_\_

How many supportive people (those on whom you can depend) do you currently have in your life?

\_\_\_ None (0) \_\_\_ Some (1-5) \_\_\_ Many (5+)

Have you ever attended a support group that addresses the topic(s) for which you are seeking counseling?

\_\_\_ Yes \_\_\_ No (If yes, please explain) \_\_\_\_\_

Are you presently taking any medication(s) for emotional reasons? \_\_\_ Yes \_\_\_ No (If yes, please describe) \_\_\_\_\_

Have you ever been hospitalized for emotional/psychological concerns? \_\_\_ Yes \_\_\_ No (If yes, please explain)

**Do you experience such things as (check all that apply):**

**Is this current or in the past (or both)?**

|  |                              |                             |                                  |                               |
|--|------------------------------|-----------------------------|----------------------------------|-------------------------------|
| Migraines  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| Stomach Problems                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| Sleep Difficulties                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| How many hours of sleep do you get each night? _____ |                              |                             |                                  |                               |
| Sexual Difficulties                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| Frequent Crying                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| “Blue” moods   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| Anxiety/panic attacks                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| Difficulties concentrating                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| Hallucinations (visual/auditory/tactile)             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| Lack of energy                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| Racing thoughts                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| Angry outbursts                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| Eating related issues                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| Feelings of inferiority                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| Addictive behaviors                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |
| Other _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Current | <input type="checkbox"/> Past |

**Please let us know if any of the following are problem areas for you:**

|   |  |  |
|---|--|--|
| <input type="checkbox"/> Self-injurious behavior  | <input type="checkbox"/> School/work problems  | <input type="checkbox"/> Legal problems                    |
| <input type="checkbox"/> Family problems          | <input type="checkbox"/> Drug/alcohol problems | <input type="checkbox"/> Health problems                   |
| <input type="checkbox"/> Physical or sexual abuse | <input type="checkbox"/> High Risk Behaviors   | <input type="checkbox"/> Cultural/Spiritual/Moral problems |

**Abuse History**

Have you ever been physically, sexually, emotionally, or mentally abused?  Yes  No (If yes, please describe)

---



---

**Substance Use**

Do you drink alcohol or use any drugs?

Alcohol     Drugs     Both     I do not drink alcohol or use drugs

If you use alcohol or drugs, what kind do you use? Check all that apply.

|  |   |   |
|--|---|---|
| <input type="checkbox"/> Beer/Wine                                 | <input type="checkbox"/> Liquor                   | <input type="checkbox"/> Amphetamines/Speed/Meth/etc    |
| <input type="checkbox"/> Marijuana/Pot/Hash/etc                    | <input type="checkbox"/> Cocaine/Crack/etc        | <input type="checkbox"/> Hallucinogens/Acid/Ecstasy/etc |
| <input type="checkbox"/> Inhalant/Huffing/Whipits/etc              | <input type="checkbox"/> Opioids/Heroin/Opium/etc |   |
| <input type="checkbox"/> Phencyclidine/Mushrooms/etc               | <input type="checkbox"/> Sedatives/valium/etc     |   |
| <input type="checkbox"/> Over the counter/prescription medications | <input type="checkbox"/> Other: _____             |   |

If you use alcohol or drugs, how often do you use them?

|  |   |
|--|---|
| <input type="checkbox"/> Every day               | <input type="checkbox"/> Several times per week |
| <input type="checkbox"/> Several times per month | <input type="checkbox"/> Once or twice a month  |
| <input type="checkbox"/> Several times per year  | <input type="checkbox"/> Once a year            |
| <input type="checkbox"/> Other: _____            |   |

**If one of the above substances has been checked, follow-up with:**

Have you ever felt like you should cut down on your alcohol or other drug use (including prescription drugs)?  Yes  No (If yes, please describe) \_\_\_\_\_  
\_\_\_\_\_

Has a friend or relative discussed concerns about your use?  Yes  No (If yes, please describe) \_\_\_\_\_  
\_\_\_\_\_

Have you ever felt guilty about your drinking or drug use?  Yes  No (If yes, please describe) \_\_\_\_\_  
\_\_\_\_\_

Have you ever had to take a drink or use a drug the next day to steady your nerves?  Yes  No (If yes, please describe)  
\_\_\_\_\_

Are you in recovery from any addictive behavior?  Yes  No (If yes, please describe) \_\_\_\_\_  
\_\_\_\_\_

Is there a history of problems with alcohol or drug use in your family (immediate or extended)?  
 Yes  No (If yes, please describe)  
\_\_\_\_\_  
\_\_\_\_\_

Do you engage in any of the following behaviors in such a way that it may be an issue for concern?

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Gambling     | <input type="checkbox"/> Sexuality   |
| <input type="checkbox"/> Spending     | <input type="checkbox"/> Eating (overeating, restricting, binging/purging) |
| <input type="checkbox"/> The Internet | <input type="checkbox"/> Exercise  |
| <input type="checkbox"/> Other: _____ |  |

Sometimes when people feel depressed or overwhelmed, they think that they'd be better off dead. Have you ever thought about suicide?  Yes  No (If yes, explain and follow-up with a thorough assessment [e.g., SLAP])  
\_\_\_\_\_  
\_\_\_\_\_

**\*\* What positive things do you do that impact your emotional health (e.g., meditation, read, exercise, etc.)?**  
\_\_\_\_\_  
\_\_\_\_\_

**LEGAL HISTORY / SOCIAL AGENCY INVOLVEMENT**

Do you have any past/current legal issues?  Yes  No (If yes, please describe) \_\_\_\_\_  
\_\_\_\_\_

Have you ever had any involvement with the Department of Children & Families or a similar agency in another state?  
 Yes  No (If yes, please describe) \_\_\_\_\_  
\_\_\_\_\_

Have you ever been involved in any kind of domestic violence?  Yes  No (If yes, please describe) \_\_\_\_\_  
\_\_\_\_\_

**EDUCATIONAL HISTORY**

What is the highest grade you have completed?

- Some high school       GED       Special High School Diploma  
 High School Diploma    Some College       AA/AS Community College  
 Bachelor's degree       Master's degree       Specialist's degree  
 Doctorate degree

Are/were you in any special education/exceptional education program?  Yes  No

If yes, what kind of program?

- Physically Impaired       Occupational Therapy       Speech Therapy  
 Language Impaired       Hearing Impaired / Deaf       Vision Impaired  
 Emotionally Handicapped       Learning Disability       Gifted  
 Hospital / Homebound       Deaf/ Blind       Autistic  
 Severely Emotionally Disturbed       Educable Mentally Handicapped

Do/did you have an Individualized Educational Plan (IEP)?  Yes  No

Do/did you have any disciplinary problems in school?  Yes  No

If yes, check all the following that apply:

- Suspension    Expulsion    Referrals    Alternative schools (e.g., Excel)  
 Other \_\_\_\_\_

Please describe:

\_\_\_\_\_

How would you rate your overall school experience on a scale from 1-5, where 1 is extremely negative and 5 is extremely positive?

- 1       2       3       4       5  
 Negative      Average      Very Positive

**EMPLOYMENT HISTORY**

Are you currently employed?  Yes, full-time    Yes, part-time    No

If yes, how long have you been employed? \_\_\_\_\_

What is your current occupation and employer? \_\_\_\_\_

Are you currently receiving disability?  Yes  No (If yes, please describe) \_\_\_\_\_

Have you ever been terminated from employment?  Yes  No (If yes, please describe) \_\_\_\_\_

**SPIRITUAL/RELIGIOUS BACKGROUND**

Current spiritual/religious practice: \_\_\_\_\_

Frequency that you practice your spirituality/religion (circle): 0 1 2 3 4 5 6 7 8 9 10+ times per week

Do you consider yourself a spiritual person?  Yes       No       Uncertain

Do you consider yourself a religious person?  Yes       No       Uncertain

Do you believe in a Higher Power?  Yes       No       Uncertain

Is your spirituality/religion a source of strength?  Yes       No       Uncertain

Would you like your counselor to address how your spirituality/religion might assist you in the counseling process?

- Yes       No       Uncertain

**RELATIONSHIP INFORMATION** (If you are in a committed relationship, please complete the following)

Relationship Status:     Single     Partnered     Married     Cohabiting and unmarried  
                                   Engaged     Separated     Divorced     Widowed

Name of spouse/partner: \_\_\_\_\_

Address (if different from yours):  
 \_\_\_\_\_

Spouse's/partner's occupation: \_\_\_\_\_

Have either of you ever filed for divorce?  Yes  No (if yes, please describe when): \_\_\_\_\_

Have you ever been separated?  Yes  No (if yes, describe when and for how long)

\_\_\_\_\_

Date of this marriage/partnership: \_\_\_\_\_

How long did you know your spouse/partner before marriage/partnership? \_\_\_\_\_

Give brief information about any previous marriages/partnerships: \_\_\_\_\_

Rate your current marriage/partnership:  Unhappy     Average     Happy     Very Happy

Is your marriage/partnership something that should be addressed in counseling?  Yes  No  Uncertain

Is your spouse/partner willing to come for counseling?  Yes  No  Uncertain

If your marriage/partnership is a cause of concern, briefly share how it impacts your current concern(s): \_\_\_\_\_

List all the children that are in your life:

| PM* | Name | Age | Gender (M/F) | Lives w/you (yes/no) | Any current concerns? |
|-----|------|-----|--------------|----------------------|-----------------------|
|     |      |     |              |                      |                       |
|     |      |     |              |                      |                       |
|     |      |     |              |                      |                       |
|     |      |     |              |                      |                       |
|     |      |     |              |                      |                       |

\*Check this column if child is by a previous marriage/relationship.

**FAMILY BACKGROUND**

If you were raised by anyone other than your own parents, please explain:

\_\_\_\_\_

Answer this section describing your own parents or parent substitutes:

Still living (yes/no):                      Father \_\_\_\_\_                      Mother \_\_\_\_\_

Occupation:                                      Father \_\_\_\_\_                      Mother \_\_\_\_\_

Parents' relationship status:  Single     Engaged     Married     Cohabiting and unmarried  
     Partnered     Separated     Divorced     Widowed

Length of their relationship:    \_\_\_\_\_ Year(s)    \_\_\_\_\_ Months(s)

Rate your parents' relationship: \_\_\_ Unhappy \_\_\_ Average \_\_\_ Happy \_\_\_ Very Happy

Rate your childhood: \_\_\_ Unhappy \_\_\_ Average \_\_\_ Happy \_\_\_ Very Happy

Where there significant events that occurred in your childhood that you feel impacts your current situation?

\_\_\_ Yes \_\_\_ No (if yes, please describe briefly): \_\_\_\_\_

How many older brothers \_\_\_\_\_ and sisters \_\_\_\_\_ do you have?

How many younger brothers \_\_\_\_\_ and sisters \_\_\_\_\_ do you have?

Are there any significant issues that occurred/are occurring with your siblings that warrant attention?

\_\_\_ Yes \_\_\_ No (If yes, please describe) \_\_\_\_\_

Have there been any deaths in your family during the last year? \_\_\_ Yes \_\_\_ No (If yes, describe below)

This concludes the psychosocial portion of your intake process. Thank you for taking the time to complete this Inventory with your counselor. The information that you have supplied will help us to provide you with the best service possible. We look forward to serving you!