Augusta Behavioral Health
79 North Medical Park Drive, Fishersville, VA 22939
Phone 540.213.2525 Fax 540.213.2555

**Patient Name**_____ **DOB**_____ **Today's Date:** _____

***ADULT Psychosocial Data – Self-Report and Therapy Notes*** *(page 1 of 2)*

1. **For what reason have you come here today?** _____

*It helps focus our assessment to have the following information about you and your life:*

2. **CHILDHOOD History:**
Are you aware of any DEVELOMENTAL DELAYS as a child? ( ) No ( ) Yes _____
Did you have any LEARNING DIFFICULTIES as a child? ( ) No ( ) Yes_____
Any RELIGIOUS UPBRINGING as a child? ( ) None ( ) Protestant ( ) Catholic ( ) Other_____
**Did you experience ABUSE, NEGLECT or TRAUMA as a CHILD**? ( ) No ( ) Yes _____
_____
With whom did you live growing up? _____
I was child # _____ with_____ brothers and _____ sisters growing up.
# # #

3. **FAMILY/ RELATIONSHIP History:**
Is there a family history of substance abuse? ( ) No ( ) Yes Who/What_____
Is there a family history of mental Illness? ( ) No ( ) Yes Who/What_____
Is there a family history of completed suicide? ( ) No ( ) Yes Who/How_____

I have been married _____ times. Current marital status:

I have ____ living CHILDREN of a total of _____ children.
# #
My most SUPPORTIVE relationship(s) is/are with _____

My biggest PROBLEM relationship(s) is/are with_____

What is your **CURRENT LIVING SITUATION?**_____
**Have you experienced ABUSE or TRAUMA <u>as an ADULT</u>? ( ) No ( ) Yes** _____
_____

4. **EDUCATION, WORK, FINANCES:**
Highest level of **EDUCATION** completed _____
**MILITARY SERVICE**? ( ) No ( ) Yes _____
**Currently Employed**? ( ) No ( ) Yes _____
**Types of Work** over the years _____
Any serious **WORK-RELATED STRESSORS** at this time? ( ) No ( ) Yes _____
Any serious **FINANCIAL STRESSORS** at this time? ( ) No ( ) Yes _____
_____

5. **LEGAL ISSUES:**
Are there any CURRENT LEGAL ISSUES? ( ) No ( ) Yes _____
Any PAST LEGAL issues? ( ) No ( ) Yes _____

6. **SPIRITUALITY:**
Describe your current religious or **SPIRITUAL BELIEFS**, practices. For example, do you believe in a Higher Power or God, attend services, meditate_____
What provides you strength to keep going?
_____

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***ADULT Psychosocial Data – Self Report (page 2 of 2)***

**7.** Any **SEXUALITY** issues, past or present? ( ) No ( ) Yes _____
Have you been either the Victim or Perpetrator of Sexual Violence at any point in your life? ( ) No ( ) Yes

**8. COPING:**
What's been your MOST STRESSFUL LIFE EXPERIENCE(s)? _____
_____
_____

How did you cope? _____

Check the following STRENGTHS you see in yourself/ your life:

| | | | | |
|---|---|---|---|---|
| ( ) Physical Health | ( ) Family Support | ( ) Motivated | ( ) Personality | ( ) No Major Financial Stressors |
| ( ) Sense of Humor | ( ) Community Support | ( ) Energetic | ( ) Education | ( ) Employed in a Job I Like |
| ( ) Assertiveness | ( ) Supportive Friends | ( ) Hard Worker | ( ) Hobbies | ( ) Caring about Others |
| ( ) Spirituality | ( ) Children | ( ) Verbal | ( ) Pets | ( ) Insightful |

( ) Other_____

What do you CURRENTLY do for FUN and RELAXATION? _____

What did you USED TO DO for FUN and RELAXATION? _____

**9. Have you:**

| | | | |
|---|---|---|---|
| Ever had a **psychiatric hospitalization?** | ( ) No | ( ) Recently | ( ) In the past |
| Ever tried to **kill yourself**? | ( ) No | ( ) Recently | ( ) In the past |
| Had **thoughts of wanting to kill yourself**? | ( ) No | ( ) Recently | ( ) In the past |
| **Tried to harm yourself in other ways**? | ( ) No | ( ) Recently | ( ) In the past |
| **Tried to harm someone else**? | ( ) No | ( ) Recently | ( ) In the past |
| Overused alcohol or used other drugs? | ( ) No | ( ) Recently | ( ) In the past |
| Been in substance abuse treatment? | ( ) No | ( ) Recently | ( ) In the past |
| Been in counseling before? | ( ) No | ( ) Recently | ( ) In the past |

Had an appointment with a health care provider within the past month? ( ) No ( ) Yes, _____

**Circle any of the following with which you are currently experiencing problems:**
Sleep Appetite Concentration Low Energy Sex Drive Crying Spells Hopelessness *Helplessness* Low Self-Esteem

**If there is anything else helpful to know especially if you come from another country/culture, have certain beliefs?**

_____
_____

**Completed by** _____ Date_____

**Clinician Assessing/Reviewing** _____Date _____

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**STAFF ONLY/ Session Notes**: