Solution Focused
Therapy Services, LLC

501 Church St. NE Suite 106 Vienna, VA 22180
(703) 755-0995
jenniferspeedlpc@gmail.com

ADULT PSYCHOSOCIAL FORM

Date: ____/____/____

Last Name: _____ First Name: _____ Middle Initial: _____

Please answer the following questions, which will help me to obtain accurate background information that will be useful in our work together. Please skip any questions that you are not comfortable with or ready to answer, and feel free to discuss any concerns you have regarding this document in your next session. Information obtained in this document will be kept strictly confidential in compliance with HIPPA regulations.

PROBLEM ANALYSIS

1. PROBLEM DESCRIPTION: Briefly describe the problem(s) and symptom(s) for which you are currently seeking help. Please also check all that apply below.

_____

_____

_____

- ___ Very unhappy
- ___ Irritable
- ___ Temper outbursts
- ___ Withdrawn
- ___ Daydreaming
- ___ Fearful
- ___ Clumsy
- ___ Overactive
- ___ Slow
- ___ Short attention span
- ___ Distractible
- ___ Lacks initiative
- ___ Undependable
- ___ Peer/Partner Conflict
- ___ Phobia (specify) _____
- ___ Impulsive
- ___ Stubborn
- ___ Frequent Lying
- ___ Sexual Difficulties
- ___ Mean to others
- ___ Destructive
- ___ Trouble with the law
- ___ Eating problems
- ___ Self-mutilating
- ___ Sleeping problems
- ___ Sickly
- ___ Shy
- ___ Tics
- ___ Procrastination
- ___ Uncontrollable Worry (specify) _____
- ___ Nightmares
- ___ Flashbacks
- ___ Difficulty leaving the house
- ___ Panic
- ___ Communication Difficulties
- ___ Work Stress
- ___ Frequent tearfulness
- ___ Homicidal thoughts/Thoughts of harming others
- ___ Strange behavior (specify) _____
- ___ Strange thoughts (specify) _____
- ___ Drug abuse/dependence
- ___ Alcohol abuse/dependence
- ___ Suicidal Thoughts

2. PROBLEM DURATION: Approximately how long have you had the current problem(s)?

2 weeks ☐ 1 month ☐ Between 1 and 6 months consistently ☐ Between 6 months and 1 year consistently ☐

Between 1 and 6 months sporadically ☐ Between 6 months and 1 year sporadically ☐ More than 1 year ☐

3. PRECIPITATING EVENTS: Precipitating events to symptoms (e.g. major family illness or death,

divorce, moving to a new residence, etc.)?

_____

_____

_____

4. COPING ATTEMPTS: In what ways have you attempted to cope with this problem?

_____

_____

5. Have you had any difficulty falling or staying asleep recently? If so, briefly describe. **Y** ☐ **N** ☐

_____

_____

6. Have you had any recent changes in eating or appetite, or problems with your eating habits? If so, briefly describe. **Y** ☐ **N** ☐

_____

_____

7. Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere?

Y ☐ **N** ☐

_____

_____

8. Have you had previous psychological counseling? **Y** ☐ **N** ☐

If yes, to the best of your ability please note your age and duration of previous counseling experience(s):

_____

_____

9. Have you ever been hospitalized for psychiatric reasons? **Ye** ☐ **N** ☐

If yes, what hospital, approximate dates, precipitating event:

_____

_____

10. Are you currently taking prescribed psychiatric medication (antidepressants or others)? **Yes**☐ **No**☐

If yes, please list medication, dosage, and the approximate date treatment began:

_____

_____

11. If not currently prescribed medication, have you been prescribed such medications in the past? **Yes**☐ **No**☐

If yes, please list medication, dosage, and the approximate date treatment began and ended:

_____

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12. Have you ever experienced domestic violence or abuse? **Yes**☐ **No**☐

13. Have you ever witnessed domestic violence? **Yes**☐ **No**☐

14. Have you ever experienced sexual abuse, assault, or uncomfortable touching? **Yes**☐ **No**☐

15. Have you had suicidal thoughts recently (within the last month)? **Yes**☐ **No**☐

(If yes, check applicable response): Frequently☐ Sometimes☐ Rarely☐ Never☐

16. Have you had suicidal thoughts in the past? **Yes**☐ **No**☐

(If yes, circle applicable response) Frequently☐ Sometimes☐ Rarely☐ Never☐

17. Have you ever attempted suicide? **Yes**☐ **No**☐

(If yes, please list the age(s) of the attempt(s)) :_____

18. Have you ever intentionally inflicted any other form of harm upon yourself? **Yes**☐ **No**☐

19. Have you intentionally inflicted any form of harm upon anyone else recently? **Yes**☐ **No**☐

WORK & EDUCATIONAL HISTORY

1. List your current or most recent job/employment, along with your title/position. If student, please list school and current grade.

_____

_____

2. List the most recent education you have received (e.g., high school, vocational school, college).

_____

3. Difficulties in school or work (ex. Bullying, Learning Disability, frequent unemployment, etc.).

_____

PHYSICAL HEALTH

1. How many times per week do you exercise? _____ For about how long each time_____

2. Do you regularly use alcohol? **Yes** ☐ **No** ☐

How often do you use alcohol? _____

What do you typically drink? _____

Have you used more alcohol than you intended this year? **Yes** ☐ **No** ☐

Have you ever felt the need to cut down on the amount of alcohol you drink? **Yes** ☐ **No** ☐

Do you consider your alcohol consumption a problem? **Yes** ☐ **No** ☐ **Unsure** ☐

3. How often do you engage in recreational drug use? **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **Rarely** ☐ **Never** ☐

Have you ever felt the need to cut down on the amount of drugs you use? **Yes** ☐ **No** ☐

List any recreational drugs you currently use and how often you use them:

_____

Do you consider this drug use a problem? **Yes** ☐ **No** ☐ **Unsure** ☐

Do you find that you use alcohol or other drugs in order to cope with stress or other mental illnesses? **Yes** ☐ **No** ☐

4. Is there a history or alcohol/substance abuse or dependence in your family? **Yes** ☐ **No** ☐

(If yes, please specify) _____

5. Is there a history or mental health concerns or mental illness in your family? **Yes** ☐ **No** ☐

(If yes, please specify_____

6. Do you have any problems or worries about sexual functioning? **Yes** ☐ **No** ☐

(If yes, check applicable response): Lack of desire ☐ Performance Problem ☐ Sexual Impulsiveness ☐

Difficulties Maintaining Arousal ☐ Worried about STDs (Sexually Transmitted Diseases) ☐ Other ☐

7. Are you currently taking any other prescribed, over the counter medication, or vitamins (e.g., for hypertension, migraines, etc.)? **Yes** ☐ **No** ☐ If yes, please list medication, dosage, and the approximate date treatment began:

_____

_____

8. Please list any current or ongoing physical symptoms, chronic illnesses, or other health concerns or conditions (e.g. chronic pain, headaches, fibromyalgia, diabetes, etc.):

_____

SOCIAL HISTORY

1. Describe your relationship status: Single ☐ Domestic Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐

(specify): _____

2. Gender identity & preferred pronouns: _____

3. Sexual orientation: _____

4. Describe your living situation (with whom, type of housing, etc.) below:

_____

5. List any family members that are currently a source of support for you:

_____

6. List any friends that are currently a source of support for you:

_____

7. List any other sources of support (i.e. Church, activities, etc.):

_____

8. Please list any additional current stressors in your life:

_____

_____

9. Do you have any legal concerns or issues pending or had previous legal problems? **Yes** ☐ **No** ☐

(If yes, please specify)_____

Please list your goals for therapy:

_____

_____

_____

Please note any additional information that you feel might be helpful for me to know:

_____

_____

_____