LOOKING UP COUNSELING SERVICES, LLC
PSYCHOSOCIAL EVALUATION
200712980B

Identification Date: ___________ SS#: ___________________

Medicaid Number: __________________________

Name: ____ Gender: ___Male ____Female_____

Last First MI

Address: ____ Apartment #: ____________

City: ____ State: _______ ZIP: ____________

Birth Date: _____________________ Current Age: _________ Race: ____________________

Name of Person Providing Information: ____

Relationship: _______________________________ Phone Number: _____________________

Email address:____

Presenting Problem

What are you seeking help for? ____

____

____

____

Presenting Life Situation

How many are living in your household? _____

What is your family income? _____________

What are your living arrangements: ☐ Buying ☐ Renting ☐ Other

With Spouse & Children With Spouse Alone With Sexual Partner & Children With Sexual Partner Alone

With Parents With Family Alone With Friend(s) Controlled Environment

No Stable Arrangements With Children Alone

Other/Comments: ____

Feeling/Mood/Affect (CAR SCORE #1)

Score #1_______

Are you experiencing any of the following? (Check all that apply.)

___ Mood Liability ___ Poor Coping Skills ___ Suicidal Ideations

___ Homicidal Ideations ___ Depression ___ Anger

___ Anxiety ___ Euphoria ___ Change in Appetite

___ Change in Sleep Patterns ___ Other

Other/Comments: ____

How would you describe yourself? (Check all that apply.)

___ Outgoing ___ Rebellious ___ Awkward ___ Temperamental
___ Shy/Quiet ___ Calm ___ Nervous ___ Popular
___ Unpopular ___ Aggressive ___ Happy ___ Unhappy
___ Serious

Other/Comments: ____

Which of the following problems did you experience during childhood and/or adolescence? (Check all that apply.)

___ Conflict w/Mother ___ Conflict w/peers ___ Overweight ___ Underweight
___ Conflict w/Father ___ Conflict w/teachers ___ Nightmares ___ Bed Wetting
___ Conflict w/siblings ___ Drug/Alcohol use ___ Arrests/Delinquency
___ Excessive fears/worries

Other/Comments: ____

Thinking / Mental Process (CAR SCORE #2) **Score # 2______**

Do you experience any of the following? (Check all that apply.)

___ Memory Difficulties ___ Difficulty Concentrating ___ Poor Judgment
___ Obsessions ___ Delusions ___ Hallucinations
___ Learning Disability ___ Impulse Control

Other/Comments: ____

Observation		**Not Present**	**Occasionally Present**	**Repeated**
Facial Expression Suggestions	Anxiety, fear, apprehension			
	Depression, sadness			
	Anger, hostility			
	Decreased variability of expression			
Comments:				
Affect & Mood	Increased liability of affect			
	Blunted, absent, unvarying			

	Euphoria, elation			
	Anger, hostility			
	Fear, anxiety, apprehension			
	Depression, sadness			
Comments:				
Perception	Illusions			
	Auditory hallucinations			
	Visual hallucinations			
	Other types of hallucinations			
	Impaired level of consciousness			
Comments:				
Perceptual Functioning	Impaired attention span			
	Impaired abstract thinking			
	Impaired calculation ability			
	Impaired intelligence			
Comments:				
Insight	Difficulty in acknowledging psych. Problems			
	Blames problems on others or circumstances			
Comments:				
Judgment	Impaired ability to manage daily living activities			
	Impaired ability to make reasonable life decisions			
Comments:				
Thinking Content	Obsessions			
	Compulsions			

	Phobias			
	De-realizations / De-personal-ization			
	Suicidal Ideations			
	Homicidal Ideations			
	Delusions			
	Ideas of reference			
	Ideas of influence			
Comments:				

How would you describe your intellectual ability?

___ Above average ___ Average ___ Below Average ___ Mentally Handicapped

Previous mental health treatment: ___ Yes ___ No

Facility: ________________________ When: _____________________ Diagnosis: ____________ IP OP

Facility: ________________________ When: _____________________ Diagnosis: ____________ IP OP

How would you describe yourself? (Check all that apply.)

___ Withdrawn	___ Aggressive	___ Responsible	___ Impulsive
___ Indecisive	___ Distracted/Forgetful	___ Passive	___ Impatient
___ Rebellious	___ Confused	___ Compulsive	___ Independent
___ Immature	___ Violent	___ Agitated	___ Self Destructive
___ Shy	___ Dependent	___ Hyperactive	___ Unassertive
___ Trouble Sleeping	___ Self-confident	___ Hallucinations	___ Delusions
___ Appetite Loss	___ Loss of time	___ Other: ___________________________	

Substance Use (CAR SCORE #3) **Score #3** ______

Do you currently use Alcohol? Yes / No Drugs? Yes / No Tobacco? Yes / No

Drug of Choice	**Amount Used**	**Frequency of Use**	**Date First Used**	**Date Last Used**

Please list any family members with drug/alcohol problems: ____
____
____
____

Describe any risk taking behaviors: ____
____
____

Medical / Physical (CAR SCORE #4) **Score #4 ______**

Current health condition: ___ Good ___ Fair ___ Poor

Do you suffer from any of the following? (Check all that apply.)

___ Heart disease ___ Diabetes ___ Liver/kidney problems
___ High blood pressure ___ Chronic pain/arthritis ___ Asthma/breathing problems
___ Stroke ___ Thyroid problems ___ HIV/AIDS
___ Seizure disorder ___ Cancer ___ STD at risk behaviors
___ Hx of head injury ___ Hepatitis __ ___ Dementia

Comments: ____
____

Are you currently pregnant? ___ Yes ___ No Due Date: ____________________________

Please list any known allergies and/or adverse reactions to medications, foods, or other substances: _____________
____
____
____

Primary Care Physician: ____ Phone: _______________

List the prescription medications you are presently taking and / or have taken in the past.

Name of Medication	Strength	Dosage	Dates (From / To)	Benefits / Side effects

Were / are any of these medications effective? ____

____

____

Hospitalizations: ___ Yes ___ No

Place	Date	Reason	Length of Stay

Family/Marital/Personal History (CAR SCORE #5) **Score #5 ______**

Family of Origin:

___ Natural Parents ___ Father/Step Mother ___Mother/Step Father

___ Father Only ___ Mother Only ___ Grandparents

___ Other Family Members ___ Foster Parents ___ Adoptive Parents

Other/Comments: ____

____

You have (number):

_______ Older Brothers _______ Older Sisters _______ Younger Brothers _______ Younger Sisters

Please check any of the following that apply:

___ Parents Divorced ___ Difficulty remembering childhood/unable to describe childhood

___ Parents argued frequently ___ Family experiences severe financial distress

___ Were you physically abused? If yes, by whom? __________________

Other/Comments: ____

____

Number of Marriages: __________________ Length of time with Current Partner: ____________________

Number of Children: ____________________ Do your children live with you: ___YES ___ NO

If not, with whom and where do they live? ____

Do you have problems with your children? ___YES ___NO If "Yes", please describe:___________________

____

____

How would you describe your current partner? (Check all that apply.)

___Warm ___Abusive ___ Tense ___Affectionate
___ Boring ___ Unhappy ___Critical ___ Dependent
___ Violent ___ Distant ___"Perfect" ___ Indifferent
___ Caring ___ Happy ___ Alcohol/Drug Dependent

Other/Comments: ____

____

Is there violence in the home where you live now? ___Yes ___No

If "Yes", please describe: ____

____

Which of the following problems, if any, do you have with your current partner? (Check all that apply.)

___Money Conflicts ___Physical Abuse ___Jealousy ___Conflict over/about children
___ Conflicts of Sex ___ Affairs ___ Conflict over drug/alcohol use

Other/Comments: ____

____

Does your family have a history of mental illness? ___ Yes ___ No

If "Yes", please describe: ____

____

If your family involved in DHS/Child Welfare System or Family Court System? ___ Yes ___ No

Social Worker: ______________________ CASA Worker: ______________________

County: ______________________ County: ______________________

Interpersonal Relationships (CAR SCORE #6) **Score #6** ______

Are you difficulties with any of the following? (Check all that apply.)

___ Peers/friends ___ Social interaction ___ Withdrawal
___ Making/keeping friends ___ Conflict

Do you have family or friends in whom you can confide, or call upon for support? ___Yes ___ No
I have positive/satisfying relationships in my family. ___ Yes ___ No
I have positive/satisfying relationships outside of my family. ___ Yes ___ No
I have negative/conflicting relationships in the family. ___ Yes ___ No
I have negative/conflicting relationships outside the family. ___ Yes ___ No
Are you involved in social activities? ___ Yes ___ No
Have you ever abused another person/people? ___ Yes ___ No
Do you have a history of abusing animals? ___ Yes ___ No
Do you have a history of starting fires? ___ Yes ___ No
Do you have a history of drug abuse? ___ Yes ___ No

Comments: ____

Sexual History (Please check any of the following that apply to you.)

___ Rape/sexual assault ___ Sexual conflict/guilt ___ Sexual Identity Conflict
___ Problems with sexual performance ___ Ever had a sexually transmitted disease
___ Ever been under the influence of drugs during sex

As a child or youth, did any inappropriate sexual behavior take place around you or directed toward you? YES No
If yes, by whom? ________________________________ At what age(s)? ______________________
At what age did you start dating?______________________ Are you currently sexually active? YES No
Other significant sexual history: ____
____
____

Role Performance (CAR SCORE #7)

Score #7 ______

Have you ever served in the military? ___ Yes ___ No
*Please select one of the following:
A.______Currently active B._______ Previously Active C.________National Gurard/Reserve
If yes, what branch? ___________________________ How long? ________________________
In combat? ___ Yes ___ NO If so, where and when?_________________________________
Terms of discharge: ____________________________ Date of discharge: ____________________
*Have any of your family members served in the military? If so, what is their status?
D._____Currently Active E.______Previously Active. F______National Guard/Reserve G_______None

Are you currently employed? ___Yes ___ No Occupation: _______________________________
Hours per week you work: __________ Length of time at current job: ________________________
What is your feeling/attitude toward your job? ___Enjoyable ___Neutral ___Not enjoyable
Are you experiencing problems on your job? ___Yes ___ No
If "Yes", please describe: ____
____

Please check your economic resources:
___ Employment ___ SSI ___ Disability ___ TANF
___ Food stamps ___ Other: ______________________________

Current School System Enrolled: ____________________________ Number of Schools Attended: _______

Name of School	**Address**	**Dates**

Does the client have an IEP/504 Plan? ___ Yes ___ No

How far did you go in school or what is your current grade?______________________________

If you did not graduate from high school, why not? ______________________________

Has the client been suspended from school in the last 90 days? ___ Yes ___ No Number of days: ____________

Has the client been absent from school in the last 90 days? ___ Yes ___ No Number of days: ____________

Your school grades were/are:

___ Mostly A's ____Mostly A's & B's ____ Mostly C's _______Mostly D's & F's ______ Highly variable (A's to F's)

Other/Comments: ______________________________

____

____

Socio-Legal (CAR SCORE #8) **Score #8 ______**

Does the client have difficulty with any of the following? (Check all that apply.)

___ Following rules/laws ___ Authority issues ___ Legal issues

___ Aggression ___ Antisocial Behaviors

Are your on probation or parole? ___ Yes ___ No

Officer: ______________________________ County: ______________________________

	ALL TIMES	MOST TIMES	SOME TIMES	SELDOM	NEVER
I help out in the community.					
I conform to societal rules and laws.					

What do you do for recreation or leisure activities? ______________________________

____

Are there any cultural traditions or values that are significant to your family or in your life?

____

____

Are you involved in church/religion? ___Yes ___ No

Are you religious beliefs a significant factor in your life? ___ Yes ___ No

Other/Comments: ______________________________

____

	Once	2 - 4 Times	More than 4 Times
I have received a traffic ticket. YES NO			

I have received a traffic ticket this year. YES NO			
I have had a DUI. YES NO			
I have had a DUI this year. YES NO			
I have had contact with the law. YES NO			
I have had contact with the law this year. YES NO			

Self-Care/Basic Needs (CAR SCORE #9) **Score #9 ______**

	ALL TIMES	MOST TIMES	SOME TIMES	SELDOM	NEVER
I am able to plan for and purchase my basic needs.					
I am able to plan for and purchase food.					
I am able to plan for and purchase clothing.					
I am able to plan for a purchase housing.					
I am able to plan for and purchase transportation.					

How are your basic needs met? ____

____

How would you describe the quality of your life? ______________________________________

____

____

What needs to happen to improve the quality of your life? ______________________________

____

____

Please list strengths and abilities

1 ______________________________ 2 ______________________________

3 ______________________________ 4 ______________________________

Please list liabilities

1 ______________________________ 2 ______________________________

3 ______________________________ 4 ______________________________

Please list client needs

1 ______________________________ 2 ______________________________

3 ______________________________ 4 ______________________________

Community Integration

Please describe your ability to connect/engage in the community: ____________________

____

____

Please describe your hobbies, social activities, etc.: ____________________

____

____

Care Giver Resources

(This domain is MANDATORY for clients under the age of 21.)

Please describe any difficulties in providing housing or developmental needs: ____________________

____

____

Who is your legal guardian? ____________________ Relationship: ____________________

Are they willing to participate in treatment with you? ___ Yes ___No

Communication

What is your primary method of communication? ____________________

Are you fluent in any other languages? ____________________

Please describe any motor, speech, hearing, and/or language issues.: ____________________

Other/Comments: ____________________

____

Diagnostic Impressions

Diagnosis: ____________________

Medical:____________________

Level of Functioning: ____________________

Case Management:
___ Housing ___ Clothing ___ Childcare ___ Transportation
___ Utilities ___ Medical ___ Dental ___ Educational
___ Food ___ Household Needs ___ Other: ____________________

Indicate below what services the client is seeking:

___ Individual Therapy ___ Group Therapy ___ Family Therapy
___ Interactive Therapy ___ Marital Therapy ___ Individual Rehab
___ Group Rehab ___ Case Management ___ Other

Other/Comments: ____________________

____

Specialized Treatment: ____________________

Developmental History

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Clinician's Assessment

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Clinician's Summary

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Clinician's Signature, Credentials Date