Community Counseling of Central Connecticut Inc. 53 Muir Ave Bristol, CT. 06010

860-582-7904

cccofcentralct.org

We treat people not privilege...

Psychosocial Assessment Summary

Client Name:	Client #:	Adm. Date:
Treatment history:		
		
Medical: (Anything that could potentially i	interfere with treatment)	
	<u>,</u>	
Psychiatric: (Past and present)		
		
Current family circumstances (Famhealth)	nily members, living situa	ation, social, ethnic, cultural, emotional,

Client Name:	Client #:	Adm. Date:
Environment/home: (current	and recent past)	
Family of origin: (Siblings, ch	ildhood history, family history of m	ental illness/ substance abuse)
Need for family participation	on: (If none state why)	
Ethnic/Cultural: (Is there anyt	hing that would significantly effect	treatment).
Employment history / occu	ipational:	
Educational / Vocational:		

Client Name:	Client #:	Adm. Date:	
Legal:			
Sexual orientation / Sexua	al concerns:		
	-		
		 	
History of abuse: (Sexual, p	physical, as a victim or perpetrator)		
Grief and loss: (Does the clie	ent see this as a large factor in curr	ent problems?)	
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Spirituality / religion: (How	important does client view religion	in treatment- if any)	
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Military history:			
			

Client Name:	Client #:	Adm. Date:	
Leisure / recreational:			
Social / peers:			
Current drug including alcoho	l use? In recovery/add	icted?	
General appearance / observa	tions: (Affect, mood, though	nt content, insight etc.)	
DSM IV TR: Axis I			
Axis II-			
Axis III-			
Axis IV-			
Axis VCurrent	Past Year		
Clinician Signature:	D	ate:	