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PSYCHOSOCIAL ASSESSMENT

Date:

Name_____ Address_____

Birthdate_____ Gender_____

Home phone (May we leave a message?)_____

Cell phone/other (May we leave a message?)_____

Email (May we email you?)_____

Emergency contact (name, relationship, phone number)

_____

How did you hear about Yogalena Therapeutics?_____

How many people in your household?_____

On a scale of 1-10, 1 being very stressful and 10 being excellent, what would you rate your current living situation?_____

What are your income sources?_____

What significant life changes or stressful events have you experienced recently?

_____

_____

What significant life changes or stressful events have you experienced in the past?

_____

_____

Have you previously received mental health services? If yes, please provide practitioner information.

_____

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Have you previously received wellness, complementary, or holistic services? If yes, please provide practitioner(s) information.

_____

_____

What medications are you currently taking?

_____

_____

What supplements are you currently taking?

_____

_____

RELATIONSHIPS

Relationship Status_____

If none, when was your last relationship, and how would you describe that relationship?

_____

One a scale of 1-10, 1 being poor, 10 being excellent, what would you rate your relationship?

_____

Children/Age_____

Pets_____

HEALTH

How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very Good Excellent

What are your health goals?

_____

_____

What are your main physical health concerns?

_____

_____

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How would you rate your current emotional/mental health?

Poor Unsatisfactory Satisfactory Good Very Good Excellent

Emotional/mental health concerns?

_____

_____

Any other concerns?

_____

_____

Serious illness, injuries, hospitalizations

_____

_____

Do you experience chronic pain? If yes, please describe

_____

_____

Allergies_____

Are you allergic or do you avoid any foods?

_____

_____

Mother's physical and mental health history

_____

_____

Father's physical and mental health history

_____

_____

Siblings' physical and mental health

_____

_____

Do you have a history of substance abuse?_____

Do you drink alcohol?

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Daily Weekly Monthly Infrequently

Do you have a history of domestic or intimate partner violence?_____

How many hours/night on average do you sleep? _____

How would you rate your sleeping habits/quality of your sleep?

Poor Unsatisfactory Satisfactory Good Very Good Excellent

Describe any difficulties or changes in appetite or eating patterns

FITNESS

What forms of exercise do you do? How often?

_____

_____

WORK

What is your occupation?_____

On a scale of 1-10, 1 being very stressful and 10 being excellent, what would you rate your current job?_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

SUPPORTS

Do you have supportive family members?_____

Do you have supportive friends, social groups or outings?_____

Do you have community support from neighbors, church, fitness center, etc?_____

Do you consider yourself to be spiritual/religious?_____

What are some things you do to cope with stress?

_____

_____

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What do you consider to be your personal strengths?

_____

_____

PLAN

What do you hope to accomplish in mind/body psychotherapy?

_____

_____

Short term goal #1

_____

_____

Short term goal #2

_____

_____

Long term goal

_____

_____

Signature_____ Date_____

Alena Gerst, LMSW-RYT_____ Date_____