

Example of a Psychosocial Assessment

Name: _____
Gender: _____ Date of Birth: ____ / ____ / ____
Marital Status _____ Race/Ethnicity: _____
Languages Spoken: _____

Chief Complaint: _____

History of Present Illness: _____

Past Psychiatric/Psychological History: _____

Past Medical History: _____

Past Surgical History: _____

Allergies: _____

Current Medication List

| <i>Medication</i> | <i>Dose</i> | <i>Frequency</i> | <i>Prescriber</i> | <i>Reason</i> |
|-------------------|-------------|------------------|-------------------|---------------|
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Past Medication List

| <i>Medication</i> | <i>Dose</i> | <i>Frequency</i> | <i>Reason Started</i> | <i>Reason Stopped</i> |
|-------------------|-------------|------------------|-----------------------|-----------------------|
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Drug/Alcohol Assessment

| Which substances are currently used | Method of use (oral, inhalation, intranasal, injection) | Amount of use | Frequency of use (times/month) | Time period of use | Which substances have been used in the past |
|---|---|---------------|--------------------------------|--------------------|---|
| <input type="checkbox"/> Alcohol | | | | | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Caffeine | | | | | <input type="checkbox"/> Caffeine |
| <input type="checkbox"/> Nicotine | | | | | <input type="checkbox"/> Nicotine |
| <input type="checkbox"/> Heroin | | | | | <input type="checkbox"/> Heroin |
| <input type="checkbox"/> Opiates | | | | | <input type="checkbox"/> Opiates |
| <input type="checkbox"/> Marijuana | | | | | <input type="checkbox"/> Marijuana |
| <input type="checkbox"/> Cocaine/Crack | | | | | <input type="checkbox"/> Cocaine/Crack |
| <input type="checkbox"/> Methamphetamines | | | | | <input type="checkbox"/> Methamphetamines |
| <input type="checkbox"/> Inhalants | | | | | <input type="checkbox"/> Inhalants |
| <input type="checkbox"/> Stimulants | | | | | <input type="checkbox"/> Stimulants |
| <input type="checkbox"/> Hallucinogens | | | | | <input type="checkbox"/> Hallucinogens |
| <input type="checkbox"/> Other: _____ | | | | | <input type="checkbox"/> Other: _____ |

Suicidal/Homicidal Ideation

Is there a suicide risk? No Yes
 Previous attempt (When: _____)
 Current plan Means to carry out plan Intent Lethality of plan
Is the patient dangerous to others? Yes No
Does the patient have thoughts of harming others? Yes No
If yes: Target: _____
Can the thoughts of harm be managed? Yes No
 Current plan Means to carry out plan Intent Lethality of plan
High risk behaviors
 None Cutting Anorexia/Bulimia Head Banging
 Self injurious behaviors
 Other: _____

Abuse Assessment

In the past year has the patient been hit, kicked, or physically hurt by another person?

Is the patient in a relationship with someone who threatens or physically harms them?

Has the patient been forced to have sexual contact that they were not comfortable with?

Has the patient ever been abused? Yes No. If yes, describe by whom, when and how.

Family/Social History

Born/raised _____

Siblings ____ # of brothers ____ # of sisters

What was the birth order? ____ of ____ children

Who primarily raised the patient? _____

Describe marriages or significant relationships:

Number of children: _____

Current living situation: _____

Military history/type of discharge: _____

Support/social network: _____

Significant life events:

Family History of Mental Illness (which relative and which mental illness):

Employment

What is the current employment status? _____

Does the patient like their job? _____

Will this job likely be done on a long-term basis? _____

Does the patient get along with co-workers? _____

Does the patient perform well at their job? _____

Has the patient ever been fired? Yes No If yes, explain

How many jobs has the patient had in the last five years? _____

Education

Highest grade completed: _____

Schools attended: _____

Discipline problems: _____

Current Legal Status

_____ No legal problems
_____ Probation
_____ Previous jail

_____ Parole
_____ Charges pending
_____ Has a guardian

Developmental History

Describe the childhood: ___ Traumatic ___ Painful ___ Uneventful

Describe the childhood in relation to personality, school, friends, and hobbies): _____

Describe any traumatic experiences in the childhood: (List the age when they occurred)

What is the patient's sexual orientation? ___ Heterosexual ___ Homosexual
___ Bisexual

Spiritual Assessment

Religious background: _____

Does the patient currently attend any religious services? Yes No If yes, where.

Cultural Assessment

List any important issues that have affected the ethnic/cultural background.

Financial Assessment

Describe the financial situation.

Coping Skills

Describe how the patient copes with stressful situations.

Is the patient's coping methods: ___ adaptive ___ maladaptive

Interests and Abilities

What hobbies does the patient have?

What is the patient good at?

What gives the patient pleasure?

MENTAL STATUS ASSESSMENT

(Describe any deviation from normal under each category.)

Arousal/Orientation

___ Alert ___ Sleepy ___ Attentive ___ Unresponsive ___ Oriented to person

___ Oriented to place ___ Oriented to time ___ Confused

___ Other: _____

Appearance

___ Well groomed ___ Good eye contact ___ Poor eye contact ___ Disheveled ___ Bizarre ___

Poor hygiene ___ Inappropriate dress

___ Other: _____

Behavior/Motor Activity

Normal Restless Agitated Lethargic

Abnormal facial expressions Tremors Tics

Other: _____

Mood/Affect

Normal Depressed Flat Euphoric Anxious Irritable Liable

Indifferent Careless Inability to sense emotions

Lack of sympathy

Other: _____

Speech

Normal Nonverbal Slurred Soft Loud Pressured

Limited Incoherent Halting Rapid

Other: _____

Attitude

Cooperative Uncooperative Guarded Suspicious Hostile

Other: _____

Thought Process

Intact Flight of ideas Tangential Concrete thinking

Loose associations Unable to think abstractly Circumstantial

Neologisms Racing Word Salad

Other: _____

Thought Content

Normal Phobia Hypochondriasis Delusions Obsessive

Preoccupations

Other: _____

Delusions

None Religious Persecutory Grandiose Somatic

Ideas of reference Thought broadcasting Thought insertion

Other: _____

Hallucinations

None Auditory hallucinations Visual hallucinations

Command hallucinations

Other: _____

Describe: _____

Impulse Control

Normal Partial Limited Poor None

Frequently participates in activities without planning or thinking about them

Judgment

(What would you do if there was a fire in a crowded movie theater?)

Normal Poor

Cognition/Knowledge

Orientation

Person Place Time

Attention

Can the patient spell W-O-R-L-D backwards? Yes No

Memory

Immediate recall of 3 objects ___/3 Recall after 5 minutes ___/3

Naming

Point out three objects. How many can the patient name? ___/3

Visual-spatial

Can the patient copy intersecting pentagons? Yes No

Praxis

Can the patient follow a three step command? Yes No

Calculations

Serial 7's (how many times can the patient correctly subtract 7 from 100): _____

Abstractions

Comprehends Does not comprehend

Insight

Normal Poor

Is the patient able to meet their basic needs (e. g., food, shelter, medical):

Yes No

If no, Describe:

Functional Ability

Check the area of concern

None Activities of daily living Work Finances School

Family relationships Social relationships Safety Legal

Cognitive functioning Physical health

Housing Impulse control Social skills