

Identification Label



**Mental Health Services
Psycho-Social Assessment – Adult Services**

Client Name: _____ DOB: _____

Presenting Issues and Concerns: (from Referral Sources, Parent/s, Guardian/s) _____

ASSESSMENT OF LIFE DOMAINS

Domain I - Family
Family Members and Others in the home
Indicate relationships, school/employment status and ages:
Family Members/Significant Others (not at home)
Indicate relationships, school/employment status and ages:
Comments:

Next of Kin/Contact Person		
Name: _____	Relationship: _____	Address: _____ _____
		Phone: _____

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DOMAIN II – Living Situation

Describe the current living situation and housing needs:

Financial: Describe client's financial situation and needs.

DOMAIN III – Medical Status & History

The Client is now or had had a history of:	Yes	No	If yes, what/when/where?
Any major operations?			
Any chronic or lasting physical conditions?			
Any current medical problems?			
Currently takes prescription medication/s?			
Taking medication for anxiety, depression, mood swings, etc.?			
Any allergies; or allergic reactions to any medications in the past?			Identify and describe reaction(s):
Has stopped taking a medication because they didn't tolerate it, or had bothersome side effects from it?			
Taking OTC medication/s?			
Previous medical hospitalizations?			
Serious injury?			

Client's description of general physical health or other comments:

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DOMAIN III – Medical Status & History cont'd

Describe any significant family medical history:

Who is your regular Doctor? _____

Are you in treatment with any specialist? Yes / No - If yes, who: _____

Why: _____

Last physical examination: ____/____/____ By: _____

Do you have a dentist? Yes / No – If yes, who: _____

Are you aware of any dental needs? Yes / No – If yes, describe: _____

What Pharmacy do you use?

Name: _____ Address: _____

Telephone: _____

Domain IV - Biological Assessment:

Sleep: <input type="checkbox"/> Normal <input type="checkbox"/> Excessive <input type="checkbox"/> Initial Insomnia <input type="checkbox"/> Middle Insomnia <input type="checkbox"/> Intermittent Insomnia <input type="checkbox"/> Early waking <input type="checkbox"/> Nightmares	Appetite: <input type="checkbox"/> Normal <input type="checkbox"/> Excessive <input type="checkbox"/> Decreased If decreased or excessive, describe:	Weight: <input type="checkbox"/> Gain of: _____ lb/s Over what period of time: _____ <input type="checkbox"/> Loss of: _____ lb/s Over what period of time: _____ <input type="checkbox"/> Stable: _____ lb
Experience of bladder control problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:	

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Risk Assessment – History:			
Client has a history of:	Yes	No	Describe, give date of last event:
Suicidal Gestures/Attempts			
Aggressive Behaviors toward people, animals or self			
Self-injurious behaviors/gestures			
Restricting Food/Diagnosed as Anorexic			
Binging & Purging/Diagnosed as Bulimic			
Risk Taking Behaviors			
Criminal Activity			
Inappropriate Sexual Activity			
Additional Comments:			

Previous Psychological Exam: Yes / No - If yes, date: ___/___/___ Who: _____

Previous Psychiatric Hospitalizations: Facility	Where?	When?

Developmental History			
Where there any significant developmental difficulties:	Yes	No	If yes, please describe the difficulty:
During your mother's pregnancy?			
In infancy? (birth – 2 years)			
In early childhood? (2-4 years)			
In later childhood? (5-7 years)			

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In latency? (8-12 years)			
In Adolescence? (13-17 years)			
In early adulthood? (18-22 years)			
In middle adulthood? (31-50 years)			
In late adulthood? (51 years & on)			
Additional comments:			

Substance Use History: (check all that apply)

Family alcohol/drug abuse history:

- father stepparent/live-in
- mother uncle(s)/aunt(s)
- grandparent(s) spouse/significant other
- sibling(s) children
- other _____

Substance use status:

- no history of abuse
- active abuse
- early full remission
- early partial remission
- sustained full remission
- sustained partial remission

Treatment history:

- outpatient (age(s) _____)
 - inpatient (age(s) _____)
 - 12-step program (age(s) _____)
 - stopped on own (age(s) _____)
 - other (age(s) _____)
- describe: _____

Substances used:

(complete all that apply)

- alcohol**
- amphetamines/speed
- barbiturates/owners
- caffeine
- cocaine
- crack cocaine
- hallucinogens (e.g. LSD)
- inhalants (e.g. glue, gas)
- marijuana or hashish
- nicotine/cigarettes
- PCP
- prescription _____
- Opiates

	Current use				
	First Use age	Last Use Age	Yes/No	Frequency	Amount
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Consequences of substance abuse (check all that apply):

- hangovers
- withdrawal symptoms
- sleep disturbance
- binges
- seizures
- medical conditions
- assaults
- job loss
- blackouts
- tolerance changes
- suicidal impulse
- arrests
- overdose
- loss of control amount used
- relationship conflicts
- other _____

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Have you ever been abused by another person? If yes, please complete the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Type of Abuse: _____ By Whom: _____
Was there violence in your family when you were growing up?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Type: <input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Emotional Please explain:
Were you ever abused by anyone outside of your family?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Type: <input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Emotional Please explain:
Are you currently involved in an abusive relationship?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Describe:
Have you had other traumatic experiences in your life?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Describe:

Family Mental Health History			
Family member has been diagnosed with:	Yes	No	Relationship to client:
Depression			
Schizophrenia			
Anxiety or Panic Disorders			
Phobias			
Bipolar Disorder			
Attention Deficit Disorders			
Other:			
Comments:			

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Domain V – Social/Recreational Assessment:

Review formal and informal supports the client and/or family utilize:

Review client’s and/or family’s perspectives of help givers:

Review client’s and/or family’s social networks, friendships:

Review the client’s hobbies, sports, school, and family recreation:

Domain VI - Legal:

Does the client have a:	Yes	No	Name, Address. Phone#
Guardian			
Power of Attorney Type _____ Durable? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Representative Payee			

Review client’s current involvement and history with criminal and juvenile justice systems, police involvement, probation, protection from abuse orders, other court mandated orders, legal needs, and/or issues involving custody, guardianship or payeeship.

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Domain VII - Safety:			
Current Risk Assessment			
Is/Does the client currently:	Yes	No	Describe:
Suicidal ideation?			
Has a plan/intent?			
Has access to plans/means?			
Has a history of gestures/attempts?			
Homicidal ideation?			
Has a plan/intent?			
Named a person?			
Has access to plans/means?			
Has a history of gestures/attempts?			
Has access to firearms/weapons?			
A current crisis plan is in place?			
Is likely to require crisis services?			

Review Safety of Client/family in the home, pattern of crisis, coping skills, stress management, and a crisis plan:

Domain VIII – Education/Vocational Function Assessment:

Level of Education Obtained:
Describe anything that was significant about this person's educational experience:

Describe and review any special training, vocational services or other supports received:

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Domain VIII – Education/Vocational Function Assessment: cont'd

Disability Determined <input type="checkbox"/> Yes <input type="checkbox"/> No Status: <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Pending
Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No Employment Type: _____
of hours worked: _____/week <input type="checkbox"/> Paid Employment <input type="checkbox"/> Volunteer
Briefly discuss employment history over the past 5 years:
Describe any current vocational and/or education needs or concerns:

Domain IX – Spiritual & Cultural:

Review family values, interests, rituals, traditions, spiritual and cultural connections:

Strengths and Barriers:

Client strengths (Individual, Resource, Physical, Environmental)
Client Barriers (Individual, Resource, Physical, Environmental)

