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PSYCHOSOCIAL ASSESSMENT

Service Date:
Procedure Code: H0031 *(Date of Face-to-Face)* _____ **Start Time:** _____ **Stop Time:** _____

(This assessment is due within 14 days of the date of the intake. This assessment must be completed prior to, or at the time of, the individual's person centered planning meeting development of the IPOS.)

I. PRESENTING PROBLEM *(reason why individual is seeking services)*

Past Psychiatric/Psychological History: *(including past medications)*

Current Medications, including psychotropic, over-the-counter, herbal remedies
(include all meds taken over past 6 months)

Current Medications	Dosage	Frequency	Prescribed By	Reason for prescription

Is individual compliant with medications? ___ **Yes** ___ **No** **If no, please explain:**

Allergies:

Past medical history (include hospitalizations, surgeries, physical limitations):

Family/social history (including minor children, associated needs and risk factors):

Current and past employment history (include past trainings):

Education (include highest grade completed, schools attended, special education, discipline problems, etc.):

Current Legal Status: ___ **No legal involvement**

___ **Parole** ___ **Probation** ___ **Charges pending** ___ **Previous jail** ___ **Has guardian**

II. DRUG/ALCOHOL ASSESSMENT

SUBSTANCE USE HISTORY
(Include experimentation & accidental ingestion. Include alcohol, tobacco, and caffeine)

Drug	Method	Age 1st used	Age last used	Onset of heavy use	# days used in last 30	Amount used in last 48 hrs.	1st as RX?	Last used when?	Amount used daily/weekly	Drug of choice

PSYCHOSOCIAL ASSESSMENT

SUBSTANCE USE HISTORY
(Include experimentation & accidental ingestion. Include alcohol, tobacco, and caffeine)

Drug	Method	Age 1st used	Age last used	Onset of heavy use	# days used in last 30	Amount used in last 48 hrs.	1st as RX?	Last used when?	Amount used daily/weekly	Drug of choice

Any changes in patterns of use over time? ___ **No** ___ **Yes**

Does individual ever drink or drug more than he/she intends? ___ **No** ___ **Yes**

Has individual experienced an increase in the amount he/she can use to get the same effect? ___ **No** ___ **Yes**

Is there a history of overdose? ___ **No** ___ **Yes, describe:** _____

Is there a history of seizures? ___ **No** ___ **Yes, describe:** _____

Is there a history of blackouts? ___ **No** ___ **Yes, describe:** _____

Has individual ever used medications to either get high or come down from being high? ___ **No** ___ **Yes**

With whom does individual usually use? _____

Has individual had previous substance abuse treatment? ___ **No** ___ **Yes, where:** _____

Assessment of risk in this area: _____

III. MENTAL STATUS ASSESSMENT *(Describe any deviation from the norm under each category.)*

Appearance
___ Well groomed
___ Disheveled
___ Bizarre
___ Other:

Describe:

Mood
___ Normal
___ Depressed
___ Anxious
___ Euphoric
___ Irritable
___ Other:

Describe:

Attitude
___ Cooperative
___ Uncooperative
___ Suspicious
___ Guarded
___ Belligerent/Hostile
___ Other:

Describe:

Speech
___ Normal
___ Soft
___ Loud
___ Pressured
___ Halting
___ Incoherent
___ Slurred
___ Nonverbal
___ Limited communication skills
___ Uses yes/no only
___ Uses a picture board
___ Other:

Describe:

PSYCHOSOCIAL ASSESSMENT

Motor Activity

___Calm ___Tremor/Tics
___Hyperactive ___Lethargic
___Agitated
___Other:

Describe:

Thought Process

___Intact ___Flight of ideas
___Tangential ___Concrete thinking
___Circumstantial ___Inability to abstract
___Loose Associations ___Can only follow 1- step directions
___Other:

Describe:

Affect

___Appropriate ___Inappropriate
___Sad ___Angry
___Flat ___Constricted
___Anxious ___Labile
___Other:

Describe:

Thought Content

___Normal ___Paranoid
___Morbid ___Phobias
___Somatic Complaints ___Obsessive
___Aggressive
___Other:

Describe:

Orientation:

___Person ___Responds to name
___Place ___Recognizes familiar faces or places
___Time ___Knows own daily schedule

Describe:

Psychosis:

___N/A

Describe:

Hallucinations: ___Denies

___Auditory
___Visual
___Other:

Describe:

Command Hallucinations: ___Denies

___Harm to self
___Harm to others
___Can resist commands
___Other:

Describe:

Bizarre Delusions: ___Denies

___Thought Broadcasting
___Thought Insertion
___Thought Withdrawal
___Other:

Describe:

Delusional Beliefs: ___Denies

___Religious
___Somatic
___Persecutory
___Grandiosity
___Being controlled
___Ideas of reference

Describe:

Summary/Assessment of Mental Status Exam: _____

IV. HEALTH AND SAFETY *(Assess as if person served were not in current placement.)*

Identified Risk Factors: ___None

Client Name: _____
DOB: _____
Staff Name: _____
Case Number: _____
Medicaid Number: _____

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PSYCHOSOCIAL ASSESSMENT

___ Unsafe Sex Practices
___ Pregnancy
___ Sexual Abuse
___ Alcohol/Substance Abuse
___ Self Harm
___ Aggression Toward Others
___ Verbal/Emotional Abuse
___ Children at Risk
___ Evacuation Score: _____
___ Other: _____

___ Physical Abuse
___ Residential Safety
___ IV Drug Abuse
___ Diet/Nutrition
___ Nicotine Use
___ Medication Interaction
___ Medication Management
___ Stress Related to Parenting

___ Impulsivity
___ Chronic Health Problems
___ Non-Attentive to Need for Health Care
___ Hygiene
___ Household Management
___ Physical Disability
___ Recent Loss (Parent, child, spouse, job, relationship)
___ Psychosis
___ Community Safety

Identified Needs: ___ None

___ Quarterly TD Screening - Due:
___ Vision Exam
___ Assistance With Children's Needs
___ Other: _____

___ Nutrition Assessment
___ Labs - Frequency: _____
___ Health Care Assessment/Yearly Checkup

___ Dental Exam
___ Coordination of Care

Able to meet basic needs? ___ N/A

___ Food ___ Shelter ___ Medical

Describe:

DANGEROUSNESS

A. Suicide Risk ___ None

Describe History of Suicidality:

Ideation	___ Yes	___ No
Chronic	___ Yes	___ No
Acute	___ Yes	___ No
Recent suicidal behavior	___ Yes	___ No

Presence of Risk Behavior: ___ None

Note	___ Yes	___ No
Will	___ Yes	___ No
Gives possessions away	___ Yes	___ No

Other: _____

Describe:

Presence of Risk Factors: ___ None

___ Intent
___ Means to carry out plan
___ Access to gun
___ Prior attempts
___ Lethality
___ Plan
___ Likelihood of rescue

Describe:

B. Threat of Danger to Others ___ None

Thoughts of harm to others? ___ Yes ___ No

Recent threatening behavior? ___ Yes ___ No

___ Identified target
___ Means to carry out plan
___ Prior aggression
___ Intent
___ Lethality
___ Plan
___ Can thoughts of harm be managed
___ Access to gun

Describe:

C. Presence of Other High Risk Behaviors: ___ None

___ Cutting ___ Head banging ___ Poor or dangerous relationship
___ Anorexia/Bulimia ___ Risk taking ___ Other self-injurious behavior
___ Other: _____

Describe:

D. Presence of Deterrents: ___ N/A

Describe:

E. Other Safety Concerns: ___ None

Describe:

F. Assessment of Risk: _____

V. FUNCTIONAL SUMMARY *(Clinician's view; check column as applicable)*

Function	Not Applicable	Strength	Concern		Function	Not Applicable	Strength	Concern
Daily Activities					Safety			
Family relationships					Legal			
Social Relationships					Cognitive Functioning			
School					Housing			
Work					Social Skills			
Finances					Impulse Control			
Physical Health					Responsibility			

VI. SUMMARY OF STRENGTHS, ABILITIES, NEEDS, & PREFERENCES (*Clinician's view with client's input)*

_____

VII. OBSTACLES/BARRIERS TO SUCCESSFUL OUTCOMES

_____

VIII. DIAGNOSTIC INFORMATION *(codes & nomenclature)*

***Designate "P" for primary diagnosis**

Code _____ ___ _____

PSYCHOSOCIAL ASSESSMENT

***Axis I** Code _____ ___ _____

Code _____ ___ _____

Code _____ ___ _____

Axis II Code _____ ___ _____

Code _____ ___ _____

Code _____ ___ _____

Axis III Code _____ ___ _____

Code _____ ___ _____

Axis IV *(Check all that are appropriate and specify the problem☺*

___ Problems with primary support group	Specify:
___ Problems related to the social environment	Specify:
___ Educational problems	Specify:
___ Occupational problems	Specify:
___ Housing problems	Specify:
___ Economic problems	Specify:
___ Problems with access to health care services	Specify:
___ Problems related to interaction with the legal system / crime	Specify:
___ Other psychosocial & environmental problems	Specify:
___ None	

Axis V _____

OUTCOMES:

GAF/GAS: _____

CAFAS: _____

Multnomah: _____

IX. TREATMENT/SERVICES/SUPPORTS RECOMMENDATIONS FOR CLIENT/FAMILY

(*Add a **bold** letter from the list below to each checklist item (rather than a checkmark) to indicate activity required).*

Link **C**oordinate **P**rovide **T**rain **M**onitor **I**nstruct **A**ssess **R**efer **AD**vocate

___ Psychiatric Consultation	___ Community Support	___ Individual Therapy
___ Psychological Evaluation	___ Medication Assistance	___ Group Therapy
___ Speech/Language	___ Nursing Support	___ Family Therapy
___ Occupational Therapy	___ Housekeeping	___ Dual Diagnosis Group
___ Physical Therapy	___ Family Education	___ Social Activity/Recreation
___ Group Home/AFC	___ Employment Assistance	___ Housing Assistance
___ Assistance with Benefits	___ Money Management	___ ADL Instruction
___ Physical Health Assessment	___ Dietary/Nutrition	___ Transportation

___ Dept. of Human Services (formerly FIA) ___ Community Action

Client Name: _____

DOB: _____

Staff Name: _____

Case Number: _____

Medicaid Number: _____

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PSYCHOSOCIAL ASSESSMENT

___ Social Security Administration
___ Home Health
___ Room and Board
___ Primary Health Care
___ MRS/MI Jobs Commission
___ CLF
___ Substance Abuse Assessment
___ Other (see Medicaid Chapter III / State Plan):

Initial Completion: _____

Clinician/Credentials _____ **Date:** _____

Supervisor/Credentials _____ **Date:** _____

Client Name: _____
DOB: _____
Staff Name: _____
Case Number: _____
Medicaid Number: _____