HEALTH CARE FOR THE HOMELESS, INC

PSYCHOSOCIAL ASSESSMENT

DATE: _____

PRESENTING PROBLEM:

PSYCHIATRIC TREATMENT *(begin with most recent Treatment):*

Psychiatric In-Patient History	Psychiatric Out-Patient History

PSYCHOTROPIC MEDICATION HISTORY:

Past Psychotropics	Present Psychotropics

Medical Issues/Allergies to Medications (probe conditions r/t chronic pain): _____

Family Psychiatric and Substance Abuse History? ☐ **No** ☐ **Yes** **If yes, describe:** _____

If applicable, history of alcohol and/or drugs/substance (include last use): _____

SOCIAL/ FAMILY HISTORY:

Last Grade Completed: **Last Time Employed:** **Military History - Discharge Status:**

Support System:

Living Situation/History of Homelessness: _____

History of Physical/Sexual Abuse or Domestic Violence: _____

Legal History? ☐ **No** ☐ **Yes** **If yes:** _____

CLIENT LAST NAME: **FIRST NAME:** **HCH#:**

RISK ASSESSMENT:

Suicidal Ideation? ☐ No ☐ Yes Past history of suicide attempt? ☐ No ☐ Yes

Suicidal Plan? ☐ No ☐ Yes

Last suicide attempt (including means): _____

Homicidal Ideation? ☐ No ☐ Yes Prior history of homicidal attempt? ☐ No ☐ Yes

Homicidal Plan? ☐ No ☐ Yes

Last homicide attempt (including means): _____

Consciousness: ☐ Alert ☐ Confused ☐ Lethargic ☐ Stuporous

Orientation: ☐ Person ☐ Place ☐ Time (Year, Season, Date, Month)

Interview Behavior: ☐ Cooperative ☐ Angry ☐ Silly ☐ Negativistic ☐ Evasive
☐ Superficial ☐ Irritable ☐ Withdrawn ☐ Dependent ☐ Uncooperative

Memory:

	Immediate	Recent	Past
	☐ Poor	☐ Poor	☐ Poor
	☐ Fair	☐ Fair	☐ Fair
	☐ Good	☐ Good	☐ Good

Mood:

Deoression	Mania	Other: _____
☐ Mild	☐ Mild	☐ Anxiety
☐ Moderate	☐ Moderate	☐ Mild
☐ Severe	☐ Severe	☐ Moderate
		☐ Severe

Agitation: ☐ Tense ☐ Restless ☐ Pacing ☐ Hostile ☐ NAD

Affect: ☐ Flat ☐ Blunted ☐ Full Ranged ☐ Labile ☐ Restricted ☐ Other: _____

Impulse Control: ☐ Poor ☐ Fair ☐ Good **Judgment/Insight:** ☐ Poor ☐ Fair ☐ Good

Speech: ☐ Normal ☐ Slurred ☐ Reduced ☐ Excessive ☐ Soft
☐ Loud ☐ Mute ☐ Pressured ☐ Stutters ☐ Rapid

Sleep: _____

Appetite: _____

Flow of Thought: ☐ Normal ☐ Circumstantial ☐ Tangential ☐ Blocking
☐ Perseveration ☐ Loose ☐ Flight of Ideas ☐ Indecisive

Thought Content: ☐ Rational ☐ Depressive ☐ Suspicious ☐ Poverty of ideas ☐ Phobias
☐ Obsessions ☐ Somatic Preoccupation ☐ Religiosity ☐ Referential ☐ Worthless ☐ Hopeless

Delusions Present? ☐ No ☐ Yes If yes, content: _____

Hallucinations present? ☐ No ☐ Yes If yes, describe:

Are they command hallucinations? ☐ No ☐ Yes If yes, describe:

General Cognitive Assessment: Overall estimate of IQ: ☐ Average ☐ Above Average ☐ Below Average

Potential barriers to learning/achieving treatment goals: ☐ Limited Education ☐ Cognitive deficits ☐ Poor motivation ☐ Cultural/religious
☐ Active substance use ☐ Psychosis ☐ Other: _____

Capacity to form therapeutic alliance: ☐ good ☐ fair ☐ poor

Working Diagnosis/Diagnostic Impression:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Plan: (including referrals): _____

Individualized Treatment Plan (completed at time of Intake): **Date Initiated:** _____

Short Term Goals (reviewed at 6 months)	Date Reviewed	Achieved?
1.		☐ Yes ☐ No
2.		☐ Yes ☐ No
3.		☐ Yes ☐ No
4.		☐ Yes ☐ No

Brief summary of adherence and prognosis (6 month review): _____

Signature/Title: **Date of 6 month review:**

Long Term Goals (reviewed at 1 year)	Date Reviewed	Achieved?
1.		☐ Yes ☐ No
2.		☐ Yes ☐ No
3.		☐ Yes ☐ No
4.		☐ Yes ☐ No

Brief summary of adherence and prognosis (12 month review): _____

Signature/Title: _____ **Date of 1 year review:** _____

Intake Provider's Signature: **Date:**

CLIENT LAST NAME: _____ **FIRST NAME:** _____ **HCH#:** _____