Health Care for the Homeless
INFORMATION RESOURCE CENTER
888/429-3300 • Fax 518/439-7612

#4. SOCIAL SERVICE – ASSESSMENT / RECORDS

Adult social service interview (*THU 7*)
Assessment/evaluation for services (*POR 11*)
Co-service coordination strengths assessment (*WIN 1*)
Social service risk assessment form (*THU 6*)
Social work staffing notes (*TER 4*)

THU 7

THUNDERMIST HEALTH ASSOCIATES, INC.

ADULT SOCIAL SERVICE INTERVIEW FORM

DATE:_____ REFERRAL SOURCE:_____

NAME:_____ AGE:_____ D.O.B.:_____

ADDRESS:_____

PHONE #:_____ STATUS: S M D SEP W

FINANCIAL SUPPORT:_____ MONTHLY AMT:_____ 61
WHAT SOURCE:_____ 61

OCCUPATION:_____ ABLE TO WORK?_____ 74
FAMILY SIZE: _____ HEAD OF HOUSEHOLD: YES or NO

MEDICAL COVERAGE:_____ 66

BARRIERS:_____ 77

HIGHEST GRADE COMPLETED:_____ GED:_____ EDUCATION PROGRAMS___ 69

NATIVE LANGUAGE:_____ INTERPRETER?_____ 67

TRANSPORTATION:_____ 65

ADEQUATE FOOD:_____ 62

NUTRITION ISSUES:_____ DR PRESCRIBE SUPPLEMENTS_____ 62

LIMITED READING PROFICIENCY:_____ 68

HOW LONG AT PRESENT ADDRESS:_____ 63
IF LESS THAN 1 YR., HOW MANY MOVES IN LAST YR?_____
IS HOUSING SUBSIDIZED?_____
WOULD YOU BE INTERESTED IN COMMUNAL HOUSING?_____

WHO DO YOU LIVE WITH?_____ 63
DO YOU PLAN TO STAY THERE?_____
ANY PETS?_____

WHO DID YOU LIVE WITH GROWING UP?_____
HOW WOULD YOU DESCRIBE YOUR CHILDHOOD?_____ 81
_____
_____

HOW DO YOU HANDLE ANGER OR FRUSTRATIONS?_____
_____ 82
WHAT ANGERS/FRUSTRATES YOU THE MOST?_____
_____ 82
WHAT ARE YOU MOST FEARFUL OF?_____
_____ 82
WHAT MOTIVATES YOU TO KEEP GOING?_____ 80
WHAT ARE YOUR STRENGTHS?_____ 80

ADULT

WHO DO YOU TALK TO ABOUT PERSONAL ISSUES?_____ 80

_____

HAS ANYONE EVER HURT YOU PHYSICALLY?_____ 92

HOW DID YOU FEEL ABOUT IT?_____ 92

HAVE YOU EVER BEEN TOUCHED IN A WAY THAT MADE YOU FEEL UNCOMFORTABLE?_____ 92

SEXUALLY ABUSED?_____ 92

HOW WERE YOU PUNISHED WHILE GROWING UP?_____ 82

EVER FEEL PUNISHMENT WAS UNFAIR?_____

DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF DRUG OR ALCOHOL ABUSE?_____

DO YOU LIVE WITH ANYONE WHO SMOKES?_____ DO YOU?_____ 73

HOW MUCH?_____

DO YOU USE ALCOHOL?_____

DO YOU USE DRUGS?_____ 72

WHAT IS YOUR CAFFEINE INTAKE?_____ 95

DO YOU PRACTICE SAFE SEX?_____ 96

MENTAL OR PHYSICAL DISABILITY?_____ 70

CRIMINAL ARRESTS?_____ INCARCERATIONS?_____ 83

LEGAL ISSUES?_____ 83

PAST PSYCH HISTORY:_____

PRESENT PSYCH MEDS:_____

SUICIDAL RISK?_____ 87

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FOR HIV+/AIDS PATIENTS ONLY:

WHEN WERE YOU GIVEN YOUR DIAGNOSIS?_____ 98

WHAT WERE THE CIRCUMSTANCES?_____ 98

_____

HOW DO YOU BELIEVE YOU ACQUIRED HIV?_____ 96

_____

HOW DID THE DIAGNOSIS CHANGE YOUR LIFE?_____ 98

_____

CURRENT HIV STATUS?____ASYMPTOMATIC ___SYMPTOMATIC ____AIDS 97

CURRENT T-CELL COUNT?_____

CURRENT VIRAL LOAD?_____

CURRENT HIV MEDS?_____ 97

WHO/WHAT MAKES UP YOUR SUPPORT SYSTEM? ____PARTNER ____FRIENDS ____FAMILY ____CHURCH ____AGENCIES ____PETS____OTHER_____ 80

WHAT OTHER AIDS RELATED AGENCIES HAVE YOU USED?_____

_____

****

IS THERE ANYTHING ELSE YOU NEED TO SHARE?_____

_____

_____

****

POR 11-1

City of Portland, Health and Human Services Department, Public Health Division
Healthcare for the Homeless, Mental Health & Substance Abuse Services
Assessment/Evaluation for Services
August 1997

Client name:_____ SS#_____ DOB:_____

Referral Source:_____

ISSUES

#1 - Mental Health	#2 - Substance Abuse/Addictive Disorder	#3 - Family
#4 - Social Skills	#5 - Living Situation/Housing/ADL	#6 - Financial Issues
#7 - Legal	#8 - Vocational/Education	#9 - Physical Health

SUMMARY EVALUATION

State brief assessment of current functioning, immediate needs (as perceived by both client & clinician) and initial plan and recommendations for treatment.

Diagnosis:_____ Plan:_____

Staff signature:_____ Date:_____

Supervisor signature (if needed)_____ Date:_____

POR 11-2

I. MENTAL HEALTH (including medication issues)

a. Please state the assigned diagnosis if known:

b. List any current psychotropic medications:

c. Is the client experiencing current suicidal ideation?

d. Past treatment history:

Hospitalizations:

Outpatient treatment:

Psychotropic medications:

Use of crisis services:

Self harm or suicide attempts, aggressive thoughts, threats &/or actions:

e. Current/ongoing treatment:

Provider, Site & Frequency

Type of treatment

f. Brief Mental

Status Perceptions seem reality based? Y or N (i.e. phobic, delusional, hallucinations, illusions)	Cognitive functioning intact? Y or N (I.e. memory, orientation, thought orientation)
Judgement capacity intact Y or N (i.e. conscience, insight)	Clear expression of thoughts Y Or N (i.e. loose associations, tangential, rigid, pressured?)
Appropriate affect Y Or N	Excessive anxiety Y Or N
Appropriate appearance? Y Or N	Cognitive functioning assessment indicated? Y or N
Neurological assessment indicated? Y Or N	

g.. Summary of Strengths and Needs in the area of Mental Health:

Client/guardian perceived:

Provider perceived:

II. SUBSTANCE ABUSE/ADDICTIVE DISORDER

a. Is the us/abuse of addictive substances currently a problem for you? Y Or N

b. What substances has the client used in the past 30 days? At some point in lifetime?

	30 days	Lifetime	Not at all
Alcohol use			
Alcohol to intoxication			
Heroin			
Methadone			
Other opiates			
Barbiturates			
Other sed/hyp/tranq.			
Cocaine			
Amphetamines			
Cannabis			
Hallucinogens			
Inhalants			

c. Has the client experienced "blackouts" as a result of addictive substance intoxication?

d. Has the client experienced physical withdrawal from his/her substance?

e. Has the client experienced seizures during physical withdrawal?

f. Has the client overdosed on drugs?

g. Has the client attempted to cut down or cease substance use in the past?

h. What is the client's longest period of sobriety/stability? Please describe:

i. Please describe you past treatment for alcohol or drug abuse:

j. Please describe your past detox (detox only) treatment?

k. Describe your current substance abuse treatment (include 12 step programs):

l. Does the client describe any members of his/her family as having a significant alcohol, drug or mental illness problem? Who?

Mother's	Father's	Siblings
Grandmother	Grandmother	Brother 1
Grandfather	Grandfather	Brother 2
Mother	Father	Sister 1
Aunt	Aunt	Sister 2
Uncle	Uncle	

POR 11-4

m. Summary of Strengths and Needs in the area of Substance Abuse/Addictive Disorders:
Client/guardian perceived Provider perceived

III. FAMILY/RELATIONSHIP STATUS

a. Relationship status?
Married Partnered Single Separated Divorced Widowed Remarried

b. How long has the client been in this relationship status?

c. During the past 3 years, what has been the client's usual living arrangement?

____ With sexual partner & children
____ With children alone
____ With family
____ Alone
____ No stable arrangements
____ With sexual partner alone
____ With parents
____ With friends
____ Controlled environment

d. Does the client have children? How many? With how many children, does the client have an active and ongoing relationship?

e. With friends and/or family, how are conflicts resolved? Please describe:

f. Is there any history of physical or sexual abuse for this client? Y Or N

g. What was the role of the client in this abuse? ____ Victim ____ Perpetrator

h. Summary of Strengths and Needs as regards Family issues:
Client/guardian perceived Provider perceived

IV. SOCIAL SKILLS

a. Does the client have close friends?

b. The client spends most of his/her free time with: ____ family
____ friends
____ alone

c. What activities does the client participate in during his or her free time?

l. Strengths and Needs
Client/guardian perceived Provider perceived

V. LIVING SITUATION/HOUSING/ADLs

a. How long has the client been in his/her current living situation?

b. Has the client experienced housing problems in the past six months? (eviction, non-payment of rent, inability to maintain stable roommate situation, etc.)

c. Does the client receive any type of subsidized housing?

d. Does the client receive any type of in-home support services?

e. Is the client able to independently perform the following tasks:

Food preparation	_____	Housekeeping necessities	_____
Appropriate dress	_____	Shopping	_____
Personal hygiene	_____	Transportation	_____

f. Summary of Strengths and Needs in the area of Living Situation/Housing/ADLs

Client/guardian perceived Provider perceived

VI. FINANCIAL ISSUES

a. What is this client's source of income?

Wages ____ SSI ____ SSDI ____ VA benefits ____ Other _____

b. Does the client have a representative payee? Yes ____ No ____

Who:

Rep Payee Name: _____

Address: _____

Phone: _____

c. Does the client receive food stamps? Yes ____ No ____

d. Does the client receive Medicaid? Yes ____ No ____ Medicare? Yes ____ No ____

e. How well does the client manage his money/resources?

f. Summary of Strengths and Needs in the area of Financial Issues:

Client/guardian perceived Provider perceived

VII. LEGAL

a. Is the client currently on probation or parole? Yes ____ No ____

POR 11-6

b. Does the client have a legal guardian? Yes ____ No ____
Name:_____

Address: _____

_____

c. Has the client ever been convicted of a crime (s)? (Please explain)

d. Has the client ever spent time in jail? When? How long was incarceration? How frequent?

e. Summary of Strengths and Needs in the area of Legal issues:
Client/guardian perceived Provider perceived

VIII. VOCATIONAL/EDUCATION

a. What is the highest level of education completed?

Didn't complete high school ____ GED ____ High School Diploma ____

Technical training/education ____ College ____ Other ____ Voc Rehab _____

b. What does the client consider to be his/her profession or trade or skill?

c. Was the client in the military?

d. Does the client have a valid driver's license?

e. What was the client's longest full-time employment?

f. What was the client's last period of employment? Please detail ...

g. In the last 3 years, what was the client's usual employment pattern?

Full time	Military service
Part time (regular)	Retired/disability
Part time (irregular)	Unemployed
Student	In controlled environment (jail, rehab, etc.)

h. What has been your employment status in the last 30 days?

i. Does the client have employment goals? If so, what are they?

j. Summary of Strengths and Needs in the Vocational/Educational area:
Client/guardian perceived Provider perceived

IX. PHYSICAL HEALTH

a. Does the client have a principle health care provider?

Name _____

Address _____ Phone _____

b. Date of last physical _____

c. Date of last hospitalization for physical problem? _____

d. List any other medical hospitalizations:

e. Is the client currently taking any medication on a regular basis?

f. Does the client receive a pension for a physical disability?

g. In the last 30 days, has the client experience any medical problems?

h. Does the client have any dental health issues which need to be assessed/addressed?

i. Does the client have any nutritional issues which need to be assessed/addressed?

j. Does the client have any STD/HIV issues which need to be assessed/addressed?

k. Summary of Strengths and Needs in the area of Health:
Client/guardian perceived Provider perceived

X. OTHER AREAS . . .

PLEASE SUMMARIZE
AT THE BEGINNING OF THIS DOCUMENT

WIN 1

Coordinator's Name _____ Consumer's Name _____
Date _____

CO-SERVICE COORDINATION
Strengths Assessment

CURRENT STATUS: What's going on today? What's available now?	INDIVIDUAL'S ASPIRATIONS: What would be a better future?	RESOURCES, PERSONAL AND SOCIAL: What have I used in the past?
	LIFE DOMAIN DAILY LIVING SITUATION	
	FINANCIAL	
	VOCATIONAL/EDUCATION	
	SOCIAL SUPPORTS	
	HEALTH	
	LESIURE/ RECREATIONAL SUPPORTS	

Consumer's Priorities:

_____ _____
Coordinator's Signature Date Customer's Signature Date

THUNDERMIST HEALTH ASSOCIATES
SOCIAL SERVICE RISK ASSESSMENT FORM

Patient Name:_____ Medical Record #:_____

Date of Birth:_____ Intake Date: _____

Circle Number for risk factor

SOCIAL RISKS	Date Issue Identified	Date Issue Resolved
61. Inadequate Income		
62. Inadequate Food		
63. Inadequate Shelter		
64. Inadequate Child Care		
65. Inadequate Transportation		
66. Health Insurance Problems		
67. Limited English Proficiency		
68. Illiteracy		
69. Inadequate Education		
70. Mental or Physical Disability		
HEALTH BEHAVIORS		
71. Alcohol Use		
72. Drug Use		
73. Tobacco Use – include secondhand		
74. Physical Stress		
75. Health Care Noncompliance		
77. Cultural/Religious Barriers		
PSYCHOLOGICAL RISKS		
79. Adjustment Problems		
80. Lack of Social/Family Support		
81. Dysfunctional Family		
82. Domestic Violence		
83. History of Antisocial Behavior		
84. Adoption/Foster Care		
85. Inadequate Parenting		
86. Parenting Difficulties		
87. Suicide Risk		
PEDIATRIC RISKS		
88. Medical/Social Noncompliance		
89. Current DCYF		
90. Major health problems		
91. Agency/Care Coordination problems		
92. Child Abuse/Sexual Abuse		
93. Parenting Education		
94. Home/Car Safety		
ADDITIONAL RISK FACTORS		
95. Caffeine		
96. Partner history		
97. Medication Compliance		
98. Diagnosis Adjustments		

Care Manager Assigned: YES NO

IF YES, Name of Case Manager: _____

Date Assigned:_____

TER 4

SW STAFFING NOTES

DATE: **STAFF:** _____ _____ _____ _____

PROBLEM #_____ **PROBLEM:**_____

_____

_____

Plan_____

_____

_____

Progress: _____

_____

Resolved:____ **Deferred**____ **Referred**____ **Other:**_____

_____

DATE: **STAFF:** _____ _____ _____ _____

PROBLEM #_____ **PROBLEM:**_____

_____

_____

Plan:_____

_____

_____

_____

Progress:_____

_____

Resolved:____ **Deferred**____ **Referred**____ **Other:**_____