FLORIDA DEPARTMENT OF HEALTH

Psychosocial Assessment

Directions: After the assessment interview, check off items that apply. Write information obtained from the interview. If subject area is not applicable, write N/A.

Name: _____

ID No: _____

Date of Birth: _____

Date of Initial Assessment: _____

Status:

Appearance and General Behavior

- ☐ Appropriate attire
- ☐ Clothing disheveled
- ☐ Poor hygiene
- ☐ Cooperative
- ☐ Oriented to time, place and person
- ☐ Disoriented/confused
- ☐ Pressured speech
- ☐ Psychomotor retardation
- ☐ Guarded/avoidant
- ☐ Uncooperative
- ☐ Agitated
- ☐ Other: _____

Comment: _____

Mood/Affect

- ☐ Normal mood
- ☐ Appropriate to content
- ☐ Adaptable
- ☐ Flat affect
- ☐ Angry/hostile
- ☐ Labile
- ☐ Irritable
- ☐ Inappropriate to content
- ☐ Euphoria/elated
- ☐ Anhedonia
- ☐ Depressed/sad
- ☐ Anxious
- ☐ Other: _____

Comment: _____

General Functioning/Behavior

- ☐ Able to abstract
- ☐ Logical/goal directed
- ☐ Alert
- ☐ Fully oriented
- ☐ Poor impulse control
- ☐ Potential for suicidal ideation
- ☐ Limited insight
- ☐ Poor anger management
- ☐ Low self esteem
- ☐ Decreased attention span
- ☐ Impaired concentration memory
- ☐ Social withdrawal/isolation
- ☐ Articulates needs and issues
- ☐ Impaired judgment
- ☐ Other: _____

Comment: _____

Coping Mechanisms/Resources

- ☐ Able to live independently
- ☐ Insight oriented
- ☐ Good judgment
- ☐ Able to make decisions
- ☐ Adequate problem solving skills
- ☐ Able to articulate needs/concerns
- ☐ Able to reach out to others
- ☐ Appropriate emotional expression
- ☐ Able to ask for assistance
- ☐ Adequate coping/stress management skills
- ☐ Takes responsibility for actions
- ☐ Other: _____

Comment: _____

Living Status

- ☐ Independent
- ☐ Lives with family
- ☐ Lives with partner
- ☐ Lives with friends
- ☐ Group/institutional
- ☐ Homeless/shelter
- ☐ HUD housing
- ☐ Other: _____

Comment: _____

Support Network/Resources

- ☐ Family
- ☐ Friends/co-worker
- ☐ Significant other
- ☐ Substance abuse treatment
- ☐ None
- ☐ Community support group/agencies
- ☐ 12 step program: _____
- ☐ Mental health agency: _____
- ☐ Religious/social affiliation

Comment: _____

Perception of Support System as Reported by Participant:

_____

_____

Receiving Services from Other Agencies/Service Providers: ☐ Yes ☐ No

Agencies: _____

_____

Significant Cultural/Religious Issues: ☐ Yes ☐ No

_____

_____

DH 3164, 11/98
Stock Number: 5744-000-3164-6

Name: _____

Involvement with Legal System: ☐ Current ☐ Past ☐ No
Status of Current Legal Involvement: _____

Cigarettes/Smokeless Tobacco *(Pre-contemplation)* *(Contemplation/Preparation)* *(Action)*

Current usage:	☐ Yes	☐ No	☐ Does not want to quit	☐ Wants to quit	☐ Ready to quit
Other household members:	☐ Yes	☐ No	☐ Does not want to quit	☐ Wants to quit	☐ Ready to quit

Client has (increased) (decreased) tobacco use: (cigarettes) (smokeless tobacco) (other: _____)

Education provided: ☐ Tobacco use ☐ Second hand smoke risk

# of successful (> one week) quit attempts in lifetime: _____	Has tobacco related illness: _____

If pregnant, stopped usage upon learning of pregnancy:	☐ Yes	☐ No	During pregnancy, started usage again: ☐ Yes

Alcohol

History of Dependency/Addiction:	☐ Yes	☐ No	Family History of Dependency/Addiction: ☐ Yes ☐ No	
Current Use of Alcohol:	Type: _____		Frequency: _____	Amount: _____
Readiness for Change:	☐ Pre-contemplation		☐ Contemplation/Preparation	☐ Action ☐ N/A
Alcohol treatment	☐ Yes ☐ No	Provider: _____		Last date treated: _____
If pregnant, stopped usage upon learning of pregnancy:			☐ Yes	☐ No

Other Drugs

History of Addiction	☐ Yes ☐ No		Family History of Abuse/Addiction:	☐ Yes ☐ No
Current Use	Type: _____		Frequency: _____	Amount: _____
☐ Marijuana	☐ Cocaine/Crack	☐ Hallucinogens	☐ Opiates	☐ Benzodiazepines
☐ Amphetamine	☐ Barbiturates	☐ Inhalants	☐ Prescription med.: _____	
Readiness for Change:	☐ Pre-contemplation	☐ Contemplation/Preparation	☐ Action	☐ N/A
Drug Treatment	☐ Yes ☐ No	Provider: _____		Last Date Treated: _____
If pregnant, stopped usage upon learning of pregnancy:			☐ Yes	☐ No

Mental Health History

	Current	Past
Mental health history	☐	☐
Depressed mood	☐	☐
Social impairment, including family relationship	☐	☐
Impairment in occupational functioning/ADLS	☐	☐
Impairment in school functioning	☐	☐
Other:	☐	☐
Other:	☐	☐

	Current	Past
Marital discord	☐	☐
Suicidal plan/attempt	☐	☐
Family dysfunction	☐	☐
Impairment of judgment	☐	☐
Anxious Mood	☐	☐
Poor conduct/impulse control	☐	☐
Familial history: _____	☐ Yes	☐ No

Mental Health/Substance Abuse History: Treatment/Dates/Follow-up/Response:

_____

_____

_____

_____

History of Sexual Abuse

Current:	☐ Yes	☐ No	Past Hx: ☐ Yes	☐ No
Assistance sought:	☐ Yes	☐ No	Assisted by: _____	

Situation/
Status: _____

History of Physical/Emotional Abuse or Domestic Violence

Current:	☐ Yes	☐ No	Past Hx: ☐ Yes	☐ No
Assistance sought:	☐ Yes	☐ No	Assisted by: _____	

Situation/
Status: _____

_____

Name: _____
ID No: _____
Date of Birth: _____

***If Pregnant:**
Presenting Feelings Regarding this Pregnancy/Significant Concerns and Priorities:

Significant Pregnancy History, Family Planning Issues, Child Spacing Information:

***If Adolescent Pregnancy:**
Educational Status/Issues: _____

Family/FOB Reaction to Pregnancy/Infant: _____

Attachment Issues: _____

Income/Support Issues: _____

Other: _____

Parenting

☐ Realistic expectations	☐ Parenting technique/discipline issues
☐ Unrealistic expectations	☐ Children not living in the home: _____
☐ Anger management/self-control	☐ Child protection issues: _____
☐ Parent/child interaction issues	☐ Caregivers are aware of the dangers of shaking a child
☐ Other: _____	

Parenting: Attachment Issues/Concerns/Priorities/Parental Relationship/Relationship with Children in the House:

Name:

Psychosocial Assessment/Pre-Counseling Summary
Identification of Problems/Assets/Limitations/Barriers to Care/etc. (Address Any Checked Items Requiring Further Clarification)

Psychosocial Counseling Intervention Plan
State Need for Counseling, Develop Plan with Client; Establish Goals with Dates for Completion and Frequency of Counseling Sessions.

Psychosocial Counseling Intervention Plan Update
Update Counseling Plan Goals Here. (Individual Counseling Session Progress Should be Recorded in the Progress Notes)

Date of Update: _____

Signature of Psychosocial Counseling/Assessment Provider: _____

Psychosocial Assessment Date: _____ **Title:** _____