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

_____

_____

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:** _____