Palmetto Lowcountry BEHAVIORAL HEALTH

SELF-REPORT PSYCHOSOCIAL ASSESSMENT FOR IOP AND CARE

Your Name: _____ Primary Phone #: _____ Date: _____

BACKGROUND / FAMILY INFORMATION

Who were you raised by? ❑ Biological Parents ❑ Adoptive Parents ❑ Grandparents ❑ Other _____

How is your current relationship with the individuals who raised you?_____

_____

Do you have any siblings? ❑ No ❑ Yes

If yes, how many and what is your relationship with them_____

_____

How were you disciplined as a child?_____

Do you feel that there are any significant issues from your childhood that are affecting you now? ❑ No ❑ Yes

If yes, describe_____

_____

Does anyone in your family have any history of mental illness or substance use/abuse? ❑ No ❑ Yes

If yes, describe_____

_____

HISTORY OF ABUSE

Do you have any history of physical abuse? ❑None ❑Yes Describe: _____

Do you have any history of sexual abuse? ❑None ❑Yes Describe: _____

Do you have any history of emotional abuse? ❑None ❑Yes Describe: _____

Do you have any history of abusing others (physically, emotionally, and/or sexually)? ❑No ❑Yes

If yes, describe _____

Are you currently being abused? ❑No ❑Yes: ❑physically? ❑emotionally? ❑sexually? By whom? _____

Additional details of current abuse:_____

_____

MARITAL STATUS, MARITAL HISTORY, GENDER IDENTITY/EXPRESSION, AND RELATIONSHIPS

How would you describe your sexual orientation? ❑Heterosexual ❑Homosexual ❑Bisexual ❑Gay ❑Lesbian

❑Other:_____

How would you define your gender identity? ❑Male (including transgender men) ❑Female (including transgender women)

❑Prefer to self-describe as: _____ ❑Prefer not to say

What is your current marital status? ❑Never married ❑Married: how long _____ ❑Partnered: how long _____

❑Divorced: when _____ ❑Widowed: how long _____ ❑Separated: how long _____

❑Single ❑Other: _____

Palmetto Lowcountry BEHAVIORAL HEALTH

SELF-REPORT PSYCHOSOCIAL ASSESSMENT

If in a relationship presently, how would you describe the relationship with your significant other? ❑ Not in a relationship

_____

_____

Do you have children? ❑No ❑Yes, number of children & ages:_____

How would you describe your current relationship with your children? ❑ No children

_____

_____

HOME ASSESSMENT

What is your current living situation? ❑Home ❑Shelter ❑Sober living ❑Other: _____

What is the atmosphere like in your home? ❑Loving ❑Comfortable ❑Chaotic ❑Abusive ❑Supportive

❑Other: _____

Who lives with you/with whom do you live? ❑Live alone

_____

TRAUMA/EXPLOITATION HISTORY

Have you experienced any trauma(s) or any exploitation (criminal, sexual, etc.) that you believe are impacting your current level of functioning? ❑No ❑Yes

If yes, describe: _____

_____

CULTURAL/SPIRITUAL/SOCIAL SUPPORT SYSTEM *(usual social, peer group, and environmental settings)*

Who are your primary sources of (emotional, financial, leisure time, etc.) support? _____

_____

Of the primary sources of support you listed above, would you be willing to involve any of them in your treatment? ❑No ❑Yes

If yes, please list name and number: _____

Do you have any religious or spiritual belief system? ❑No ❑Yes, describe: _____

Do you have any cultural/ethnic factors that have or may impact your treatment? ❑No ❑Yes

If yes, describe:_____

What is your preferred language and/or language spoken? _____

EDUCATION

What is the highest level of education you've completed? ❑Elementary school ❑Junior High School/Middle School

❑High School ❑GED ❑Some College ❑College ❑Trade school ❑Graduate School ❑Other:_____

Are you currently in school? ❑No ❑Yes If yes, where? _____

Are your current issues/stressors affecting your academic performance? ❑Not currently in school

❑No ❑Yes, describe:_____

_____

Palmetto Lowcountry BEHAVIORAL HEALTH

SELF-REPORT PSYCHOSOCIAL ASSESSMENT

Do you have any learning disabilities? ❑No ❑Yes, describe: _____

_____

EMPLOYMENT

Are you currently employed? ❑No ❑Yes, where and for how long? _____

Has your job been impacted by your current issues/stressors? ❑Not working, presently

❑No ❑Yes, describe: _____

_____

How many jobs have you had within the last 10 years? _____

If you are not employed, are you… ❑Unemployed ❑Disabled ❑Retired ❑Other _____

If unemployed, disabled, or retired, how long? _____

Do you need a referral to Vocational Rehabilitation? ❑No ❑Yes, why? _____

_____

MILITARY

Have you ever served in the military? ❑No ❑Yes

If yes, enlistment status (active, reserve, veteran, retired), branch, and how long in the military?_____

_____

_____

LEGAL HISTORY

Have you ever been arrested? ❑No ❑Yes, what charge(s) and when? _____

_____

Have you ever been to jail/prison? ❑No ❑Yes, describe (i.e., when and for what?):_____

_____

Do you have any pending charges or outstanding warrants? ❑No ❑Yes, describe:_____

_____

Are you currently on probation or parole? ❑No ❑Yes, who is your probation officer?_____

Have your current issues/stressors affected your legal history? ❑No ❑Yes, how so? _____

_____

_____

CURRENT FUNCTIONING

What emotions (ex. anger) are you experiencing that are not allowing you to function as usual? _____

_____

_____

What are your strengths?_____

What are your weaknesses?_____

_____

SAFETY ASSESSMENT

Are you currently having suicidal thoughts? ❑No ❑Yes

If yes, describe (i.e., do you have a plan? If you do have a plan, what is the plan?):_____

Palmetto Lowcountry BEHAVIORAL HEALTH

SELF-REPORT PSYCHOSOCIAL ASSESSMENT

Are you currently having homicidal thoughts? ❑No ❑Yes

If yes, describe (i.e., do you have a plan? If you do have a plan, what is the plan? Who are the thoughts about?):_____

_____

Do you engage in any self-harm behaviors? ❑No ❑Yes

If yes, describe (i.e., how do you harm yourself? how often do you harm yourself? when was the last time you harmed yourself?)_____

_____

Are you experiencing any symptoms of psychosis (i.e, hallucinations, paranoia, etc.)? ❑No ❑Yes

If yes, describe: _____

Do you have access to a firearm? ❑No

❑Yes, describe (what kind(s), where are they located):_____

Do you have access to medications? ❑No ❑Yes, describe: _____

Do you have access to other means of harm? ❑No ❑Yes, describe: _____

_____

Can we contact your support person to have them secure or remove these items for your safety while in treatment?

❑No ❑Yes, who would you like us to call? _____

GOALS FOR TREATMENT

Please list 2 goals you would like to achieve from being in treatment.

1. _____
2. _____

FINANCIAL RESOURCES

Are you able to support yourself without financial assistance? ❑No ❑Yes

Do you require the financial help of parents/guardians/Power of Attorney? ❑No ❑Yes

Do you need a referral for financial aid or credit counseling? ❑No ❑Yes

Have your current issues/stressors affected your financial situation? ❑No ❑Yes, how so? _____

_____

CURRENT MENTAL HEALTH AND PHYSICAL HEALTH PROVIDERS

Psychiatrist name and location: _____

Next appointment date and time: _____

Therapist name and location: _____

Next appointment date and time: _____

Primary care physician name and location: _____

Next appointment date and time: _____

Other physician/provider name and location: _____

Palmetto Lowcountry BEHAVIORAL HEALTH

SELF-REPORT PSYCHOSOCIAL ASSESSMENT

Next appointment date and time: _____

Have you ever participated in an intensive outpatient program or partial hospitalization program? ❑No ❑Yes

If yes, where and when? Did it help? _____

_____

Have you ever had a psychiatric inpatient treatment stay? ❑No ❑Yes

If yes, where and when? Did it help? _____

_____

DISCHARGE PLAN

Do you anticipate your residence changing after completing this program? ❑No ❑Yes, where will you be living?_____

_____

What are your plans after leaving this program? ❑ Psychiatrist/medication management ❑ Individual therapy

❑ 12-step program ❑ Couples/family therapy ❑ Support group ❑Other _____

BARRIERS/CHALLENGES TO DISCHARGE PLAN

Is there anything that might keep you from following up with your aftercare plan/appointments (financial, access, transportation, etc.)? _____

Are you able to get medications and take them without help/supervision? ❑No ❑Yes

Do you have the ability to follow discharge plans without help from others? ❑No ❑Yes

Do you have any history of not following your discharge plans and/or not taking medications as prescribed during previous treatment at this or any other facility? ❑No ❑Yes

If yes, explain _____

Do you have any history of being re-hospitalized because you did not take medications as prescribed or did not follow other discharge instructions? ❑No ❑Yes

If yes, explain _____

_____

Is there anything else you would like your treatment team to know? ❑No ❑Yes

If yes, what would you like to share?

Patient Signature: _____ **Date/Time:** _____

Palmetto Lowcountry BEHAVIORAL HEALTH

SELF-REPORT PSYCHOSOCIAL ASSESSMENT

THIS SECTION TO BE COMPLETED BY STAFF ONLY

Substances Used (to include substances used in past and present)

Substance	Age of First Use	Patterns of Use (i.e., continuous, episodic, binge, amounts per frequency)	Route of administration	Date of Last Use	How patient obtains (i.e, prescription, friends/family, bought elsewhere)
Tobacco ❒ Denies		Amount/freq: _____ ❒ Continuous ❒ Episodic ❒ Binge	❒ Inhale ❒ Oral ❒ Snort ❒ Injection ❒ Other:		❒ Prescription ❒ Friends/family ❒ Purchase ❒ Other:
Alcohol ❒ Denies		Amount/freq: _____ ❒ Continuous ❒ Episodic ❒ Binge	❒ Inhale ❒ Oral ❒ Snort ❒ Injection ❒ Other:		❒ Prescription ❒ Friends/family ❒ Purchase ❒ Other:
Cannabinoids ❒ Denies		Amount/freq: _____ ❒ Continuous ❒ Episodic ❒ Binge	❒ Inhale ❒ Oral ❒ Snort ❒ Injection ❒ Other:		❒ Prescription ❒ Friends/family ❒ Purchase ❒ Other:
Stimulants ❒ Denies		Amount/freq: _____ ❒ Continuous ❒ Episodic ❒ Binge	❒ Inhale ❒ Oral ❒ Snort ❒ Injection ❒ Other:		❒ Prescription ❒ Friends/family ❒ Purchase ❒ Other:
Opioids ❒ Denies		Amount/freq: _____ ❒ Continuous ❒ Episodic ❒ Binge	❒ Inhale ❒ Oral ❒ Snort ❒ Injection ❒ Other:		❒ Prescription ❒ Friends/family ❒ Purchase ❒ Other:
Hallucinogens/Psychedelics ❒ Denies		Amount/freq: _____ ❒ Continuous ❒ Episodic ❒ Binge	❒ Inhale ❒ Oral ❒ Snort ❒ Injection ❒ Other:		❒ Prescription ❒ Friends/family ❒ Purchase ❒ Other:
Inhalants ❒ Denies		Amount/freq: _____ ❒ Continuous ❒ Episodic ❒ Binge	❒ Inhale ❒ Oral ❒ Snort ❒ Injection ❒ Other:		❒ Prescription ❒ Friends/family ❒ Purchase ❒ Other:
Benzodiazepines ❒ Denies		Amount/freq: _____ ❒ Continuous ❒ Episodic ❒ Binge	❒ Inhale ❒ Oral ❒ Snort ❒ Injection ❒ Other:		❒ Prescription ❒ Friends/family ❒ Purchase ❒ Other:
Other ❒ Denies		Amount/freq: _____ ❒ Continuous ❒ Episodic ❒ Binge	❒ Inhale ❒ Oral ❒ Snort ❒ Injection ❒ Other:		❒ Prescription ❒ Friends/family ❒ Purchase ❒ Other:

Palmetto Lowcountry BEHAVIORAL HEALTH

SELF-REPORT PSYCHOSOCIAL ASSESSMENT

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SUMMARY/CLINICAL ANALYSIS

Reason for admission/readmission: _____

_____

High risk psychosocial issues requiring early treatment planning and intervention: _____

_____

_____

Necessary steps for discharge to occur: _____

_____

Social services role in treatment and discharge planning: _____

_____

_____

Patient's assessed readiness for change: ❑ Pre-contemplation ❑ Contemplation ❑ Preparation ❑ Action ❑ Maintenance

Other significant information/observations/impressions: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Therapist Signature/Credentials: _____ **Date/Time:** _____

Palmetto Lowcountry BEHAVIORAL HEALTH

SELF-REPORT PSYCHOSOCIAL ASSESSMENT

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ALCOHOL USE: BRIEF INTERVENTION NOTE

Audit C Score: _____ ☐ No/Low risk ☐ Moderate risk (if moderate complete brief intervention below.)

Patient received a brief intervention with the following elements:

a) Concern that the patient is drinking at unhealthy levels known to increase his/her risk of alcohol-related problems.

b) Feedback linking alcohol use and health, including:

- Personalized feedback explaining how alcohol use can interact with patient's medical concerns.
- General feedback on health risks associated with drinking.
- A discussion regarding abstinence (if there are contraindications to drinking) or to drink below recommended limits (specified for patient).

Patient's Response to Brief Intervention:

☐ Accepting ☐ Interested ☐ Motivated for change ☐ Patient refused to discuss alcohol use
☐ Minimizing ☐ Avoiding ☐ Resistant

Per patient's self-report, readiness to change is _____ on a scale of 0-10 (10 representing the highest level of readiness to change)

Patient ☐ ***Agreed to accept referral to outpatient counseling/program (Add appointment to aftercare plan).***
☐ ***Refused referral for treatment.***

THIS SECTION TO BE COMPLETED BY STAFF ONLY

Family/support person/significant other assessment and contact:

❑Patient refused family/support contact or does not identify a family member or support

Contact attempt #1:_____ ❑Left message ❑Unable to leave message

Therapist signature: _____ Date: _____ Time: _____

Contact attempt #2:_____ ❑Left message ❑Unable to leave message

Therapist signature: _____ Date: _____ Time: _____

Contact attempt #3:_____ ❑Left message ❑Unable to leave message

Therapist signature: _____ Date: _____ Time: _____

Date and time of contact: _____ **Person interviewed**: _____

Palmetto Lowcountry BEHAVIORAL HEALTH

SELF-REPORT PSYCHOSOCIAL ASSESSMENT

Contact phone number: _____ **Relationship:** _____

Family/support is supportive and willing to be involved with treatment. ❑Yes ❑No, describe:

_____
_____
_____

Family/support perception of illness and concerns about patient:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Goals for treatment as identified by family/support:

1. _____
2. _____

Does patient have access to means of harm? (weapons, medications, other means of harm) ❑Yes ❑No
Describe: _____

Family/support willing to remove or secure means of harm? ❑Yes ❑No ❑N/A
If no, why not? _____

Have means of harm been removed or secured? ❑N/A ❑No ❑Yes, by whom?_____
If no, why not? _____

Therapist signature/credentials: _____ **Date/Time:** _____