Consumer Name Responsible Individual/s' Name parent [] guardian []	Status: **Active** DOB: SSN: Gender: DWCCMHA #: 123456	
Address Phone:	**Current Active Case(s)** **Provider** **Open Date** Provider/Location lookup clear	
View Insurance/Medicaid Eligibility		

1. Psychosocial Assessment: Basic Information

Event Date

Use Current Date

Assessment Type

- (•) Initial ( ) Annual
- ( ) Other [Explain reason]

2. Psychosocial Assessment: Presenting Problems

Individual/Family's Description of Presenting Problem
(NARRATIVE)

Individual/Family's Determination of Cause of the Presenting Problem
(NARRATIVE)

Individual/Family Current Request for Help With Presenting Problem
(NARRATIVE)

Individual/Family Previous Efforts To Address Presenting Problem ((Check all that apply)

- ( ) None
- ( ) Isolation From Others
- ( ) Punitive Measures
- ( ) Safety Measures
- ( ) Over the Counter Medication
- ( ) Alternative Medicine
- ( ) Spiritual Healing
- ( ) Acupuncture
- ( ) Prescription Medication
- ( ) Evaluation/Intervention by Health Care Professional:
  - ( ) Primary Care Physician
  - ( ) Psychiatrist
  - ( ) Psychologist
  - ( ) Nurse
  - ( ) Social Worker
  - ( ) Physical Therapist

- Speech Pathologist
- Other
- Emergency Center Visits
- In-patient Hospitalization
- Partial Hospitalization
- Detox Program
- Substance Abuse Treatment Program
- Crisis Treatment
- Out-patient Counseling
- Intervention by Community Agency:
  - Police
  - School
  - Courts
  - Department of Human Services
  - Protective Services
  - Vocational Services
  - Self-Help Group
  - Veterans Administration
- Other:

(NARRATIVE, including dates, place, duration, frequency, outcomes, etc.)

What are the Individual's Strengths, Abilities, Interests, Individualized Needs and Preferences?
(NARRATIVE)

3. Psychosocial Assessment: Disability History (DD ONLY) N/A

DD Proxy (people with developmental disabilities only)

Predominant Communication Style

- Unreported
- English language spoken by the individual
- Assistive technology used (includes computer, other electronic devices) or symbols such as Bliss board, or other “low tech” communication devices.
- Interpreter used - this includes a foreign language or American Sign Language (ASL) interpreter, or someone who knows the individual well enough to interpret speech or behavior.
- Alternative language used - this includes a foreign language, or sign language without an interpreter.
- Non-language forms of communication used – gestures, vocalizations or behavior.
- No ability to communicate

Ability to Make Self Understood TIP

- Unreported

- Always Understood – Expresses self without difficulty
- Usually Understood – Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required
- Often Understood – Difficulty communicating AND prompting usually required
- Sometimes Understood - Ability is limited to making concrete requests or understood only by a very limited number of people
- Rarely or Never Understood – Understanding is limited to interpretation of very person-specific sounds or body language

Support with mobility

- Unreported
- Independent - Able to walk (with or without an assistive device) or propel wheelchair and move about
- Guidance/Limited Support - Able to walk (with or without an assistive device) or propel wheelchair and move about with guidance, prompting, reminders, stand by support, or with limited physical support.
- Moderate Support - May walk very short distances with support but uses wheelchair as primary method of mobility, needs moderate physical support to transfer, move the chair, and/or shift positions in chair or bed
- Extensive Support - Uses wheelchair exclusively, needs extensive support to transfer, move the wheelchair, and/or shift positions in chair or bed
- Total Support - Uses wheelchair with total support to transfer, move the wheelchair, and/or shift positions or may be unable to sit in a wheelchair; needs total support to shift positions throughout the day

Mode of nutritional intake

- Unreported
- Normal – Swallows all types of foods
- Modified independent – e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
- Requires diet modification to swallow solid food – e.g., mechanical diet (e.g., purée, minced) or only able to ingest specific foods
- Requires modification to swallow liquids – e.g., thickened liquids
- Can swallow only puréed solids AND thickened liquids
- Combined oral and parenteral or tube feeding
- Internal feeding into stomach – e.g., G-tube or PEG tube
- Internal feeding into jejunem – e.g., J–tube or PEG-J tube
- Parenteral feeding only—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)

Support with Personal Care TIP

- Unreported
- Independent - Able to complete all personal care tasks without physical support
- Guidance/Limited Support - Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity
- Moderate Physical Support - Able to perform personal care tasks with moderate support of another person

- Extensive Support - Able to perform personal care tasks with extensive support of another person
- Total Support – Requires full support of another person to complete personal care tasks (unable to participate in tasks)

Relationships TIP

- Unreported
- Extensive involvement, such as daily emotional support/companionship
- Moderate involvement, such as several times a month up to several times a week
- Limited involvement, such as intermittent or up to once a month
- Involved in planning or decision-making, but does not provide emotional support/companionship
- No involvement

Status of Family/Friend support system TIP

- Unreported
- Care giver status is not at risk
- Care giver is likely to reduce current level of help provided
- Care giver is likely to cease providing help altogether
- Family/friends do not currently provide care
- Information unavailable

Support for accommodating challenging behaviors TIP

- Unreported
- No challenging behaviors, or no support needed
- Limited Support, such as support up to once a month
- Moderate Support, such as support once a week
- Extensive Support, such as support several times a week
- Total Support – Intermittent, such as support once or twice a day
- Total Support – Continuous, such as full-time support

Presence of a behavior plan TIP

- Unreported
- No Behavior Plan
- Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
- Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee

When were you Initially diagnosed?
(NARRATIVE)

Where did the Diagnosis Occur and What triggered a diagnosis?
(NARRATIVE)

What was the Original Diagnosis?
(NARRATIVE)

What Services have been Received in the Past and Where were they Provided?
(NARRATIVE)

Supporting Documentation In Chart
○ **Yes** ○ **No** ○ **Requested**
Explain
(NARRATIVE)

4. Psychosocial Assessment: Support Circle

Number of dependents

Parental Status (consumer, no matter what age, is the natural or adoptive parent of a minor child [under 18 years old])

○ Yes ○ No ○ Unspecified

Children Served by Family Independence Agency

Child served by FIA for abuse and neglect

○ Yes ◉ No ○ Unreported

Child served by another FIA program:

◉ Yes ○ No ○ Unreported

Children Enrolled in Early On

◉ Yes ○ No ○ Unreported

	Name of Support Person and Relationship to Individual	Is Person Currently Involved?	How they Help(ed) the Individual to Function and Pursue their Dreams
1		○ Yes ○ No	

2		○ Yes ○ No	
3		○ Yes ○ No	
4		○ Yes ○ No	
5		○ Yes ○ No	
6		○ Yes ○ No	
7		○ Yes ○ No	

Is the Individual Satisfied with the Support Circle?
○ Yes ○ No

Individual's Interaction With Support Person
○ N/A ○ Not Observed ○ Appropriate ○ Remarkable….Explain (NARRATIVE)

Does the Individual/Support Person Perceive a Need to Add To/Rebuild/Strengthen/Sustain the Support Circle?
○ Yes ○ No
Explain
(NARRATIVE)

Is there a recommendation?
○ Yes ○ No

5. Psychosocial Assessment: Culture & Spirituality

Are there Any Cultural, Spiritual, or Religious Issues/Values that may Impact Services the Individual Receives?
○ Yes ○ No
If yes, please explain
(NARRATIVE)

Is there a recommendation?
○ Yes ○ No

If Yes, Recommendations
(NARRATIVE)

6. Psychosocial Assessment: Legal Involvement

Is Individual Currently Involved in the Criminal Justice Legal System?
○ Yes ○ No

Corrections-related status

07-Not under jurisdiction

Status

○ Awaiting Trial ○ In Trial ○ ○ Jail
○ Probation ○ Parole ○ Incapacitated to Stand Trial
○ Intense Probation
○ Intense Parole
○ MPRI
○ Other

Next NGRI Reviewable

Drop down Date
90 Days report Date
6 Month review Date
1 year Continuum order Date

Authorized Leave Status Contract ○ Yes ○ No Date: _____

○ Judge Name:
○ Parole Name:
○ Probation Officer Name:

Court
Agency Name

Court/Agency Address

Address

City State Zip

Phone

Repeat box if needed

Past Legal Involvement (Include Parole, Incarceration, Dates, Offenses, Treatment)

Is there a recommendation?

Yes No

Recommendations
(NARRATIVE)

Guardianship Information Start Date End Date

Name:
Relationship to Individual:
Phone:
Address:

City State Zip

Copy of Papers in Chart?
Yes No Requested Individual /Family Would Like Information

Conservator Information Start Date End Date

Name:
Relationship to Individual:
Phone:
Address:

City State Zip

Copy of Papers in Chart?
Yes No Requested Individual /Family Would Like Information

Plenary Information Start Date End Date

Name:
Relationship to Individual:
Phone:
Address:

City State Zip

Copy of Papers in Chart?
Yes No Requested Individual /Family Would Like Information

Durable Power of Attorney Information Start Date End Date

Name:
Relationship to Individual:
Phone:
Address:

City State Zip

Copy of Papers in Chart?
Yes No Requested Individual /Family Would Like Information

Yes for Adult Involvement With Legal System Continued

Psychiatric and Medical Advance Directive

Name of Patient Advocate:
Relationship to Individual:
Phone:
Address:

City State Zip

Copy of Papers in Chart?
Yes No Requested Individual /Family Would Like Information

Recommendations
(NARRATIVE)

7. PSYCHOSOCIAL ASSESSMENT: MENTAL STATUS

Mental Status

Is Individual Oriented To:

Individual Yes No Place Yes No Time Yes No Situation Yes No

Explain(NARRATIVE)

Memory

Intact Impaired Immediate Impaired Recent

Impaired Remote Not Determined

Explain
(NARRATIVE)

Awareness
Alert Dull Stupor

Explain
(NARRATIVE)

Concentration
○ Normal ○ Able to Focus ○ Distractible

Explain
(NARRATIVE)

Judgment
○ Good ○ Fair ○ Poor

Insight
○ None ○ Limited ○ Insightful

Content of Thought

○ Unremarkable ○ Illogical ○ Loosely Organized ○ Delusional

Explain
(NARRATIVE)

Hallucinations

○ Auditory ○ Visual ○ Other

Explain
(NARRATIVE)

Though Processes

☐ Unremarkable ☐ Obsessions ☐ Compulsions ☐ Paranoid

☐ Irrational ☐ Peculiar ☐ Other

Explain
(NARRATIVE)

Stream of Mental Activity

Normal	Delayed Response	Perseverating
Circumstantial	Tangential	Flight of Ideas
Slowed	Racing	Explain (NARRATIVE)
Blocked	Other	

Explain
(NARRATIVE)

Characteristic of Speech

Unremarkable	Soft	Loud
Pressured	Slurred	Incoherent
Nonverbal	Stuttering	Unintelligible

Other:

Explain
(NARRATIVE)

Mental Status Examination - Presentation During Interview

Unremarkable	Embarrassed
Seductive	Impulsive
Dramatic	Needy
Lethargic	Hyper-vigilant
Guarded	Defensive
Tearful	Controlling
	Sarcastic
Not Age Appropriate	Rebellious
Indifferent	Passive
Evasive	Belligerent
Demanding	Explain (NARRATIVE)
Other:	

Emotional State/Affect/Reactions

Appropriate	Inappropriate to Thought Content	Irritable
Angry	Calm	Apathetic
Depressed	Anxious	Absence of Emotions
Fluctuating Emotions	Ashamed	
Guilt Ridden	Jovial	
Other:		
	Explain (NARRATIVE)	

History of Emotional/Behavioral Functioning (NARRATIVE)
Current Emotional/Behavioral Functioning (NARRATIVE)

Mood as Stated by the Consumer (NARRATIVE)

8. Psychosocial Assessment: Risk Assessment

Brief Risk Assessment

Suicidal Ideation/Activity ○ Yes ○ No
Homicidal Ideation/Activity ○ Yes ○ No
Other High Risk Situation ○ Yes ○ No
Previous Suicide Attempts ○ Yes ○ No
Current Access to Lethal Means ○ Yes ○ No
No High Risk Issues Found ○ Yes ○ No

Explain (NARRATIVE)

Crisis Screening needed immediately?
○ Yes ○ No
Explain (NARRATIVE)

Immediate intervention needed?
○ Yes ○ No
Explain

(NARRATIVE)

Is there a Crisis Plan?
Yes No

Is Copy of Crisis Plan in Chart?
Yes No Requested N/A

s there a recommendation?
Yes No

Recommendations
(NARRATIVE)

9. Psychosocial Assessment: Behavioral Concerns (Check and Explain all that apply)

Target Behaviors

- Verbal Aggression
- Physical Aggression
- Self Abuse
- Noncompliance with Directives
- Truancy
- Theft
- Destruction of Property
- Hyperactivity
- Noncompliance with Medications
- Noncompliance with Hygiene
- Noncompliance with School
- Noncompliance with Work
- Sexual Deviance
- Incontinence
- Fire Setting
- Gives False Information
- Sleep Disorder
- Other:
- Eating Disorder
- None Noted

Explain all that apply:
(NARRATIVE)

Is Individual Currently on a Behavior Plan?
Yes No

If yes, written/electronic copy of Behavior Plan Provided To be Made Available Not Available

Is Behavior Plan Effective?
Yes No Depends on Situation

Does This Individual Require a Referral for a Behavioral Assessment?
Yes No

Is there a Recommendation?
Yes No

Recommendation
(NARRATIVE)

10. Psychosocial Assessment: Communication Efficiency

Communication

☐ Within Normal Limits

Expressive/Receptive Communication Problems

Hearing Impaired?
○ Yes ○ No

Explain
(NARRATIVE)

Visually Impaired?
○ Yes ○ No

Explain
(NARRATIVE)

Articulation Problem? ○ Yes ○ No
Explain
(NARRATIVE)

Fluency Problem? ○ Yes ○ No
Explain
(NARRATIVE)

Voice Problem? ○ Yes ○ No
Explain
(NARRATIVE)

Expressive Language Problem? ○ Yes ○ No
Explain
(NARRATIVE)

Receptive Language Problem? ○ Yes ○ No
Explain
(NARRATIVE)

Aides Utilized

☐ N/A
☐ Glasses
☐ Hearing Aid
☐ Dentures
☐ Use of Interpreter for Primary Language :_____ ☐ Sign Language Interpreter
☐ Use of Adaptive Communication Device:_____
☐ Use of Gestures
☐ Facial Expressions
☐ Communication Board:

	If the Individual Says or Does This...	It Means This...
1		

2		
3		
4		

Are aides being utilized effective? ○ Yes ○ No ○ Depends on Situation

Assessment is needed for:
○ Vision ○ Hearing ○ Speech ○ Dental

Is there a recommendation?
Explain
(NARRATIVE)

Activities of Daily Living

Skill	Level of Independence	Recommendations
Eating	○ Independent ○ Verbal Prompt ○ Manual/Physical Prompt ○ Dependant	
Dressing	○ Independent ○ Verbal Prompt ○ Manual/Physical Prompt ○ Dependant	
Toileting	○ Independent ○ Verbal Prompt ○ Manual/Physical Prompt ○ Dependant	
Bathing	○ Independent ○ Verbal Prompt ○ Manual/Physical Prompt ○ Dependant	
Grooming	○ Independent ○ Verbal Prompt ○ Manual/Physical Prompt ○ Dependant	
Transferring	○ Independent ○ Verbal Prompt ○ Manual/Physical Prompt ○ Dependant	

Transportation	○ Independent Use of Public Transportation ○ Needs Assistance With Use of Public Transportation ○ Able to Drive Independently ○ Dependant on Others to Drive	
Taking Medicine	○ Independent ○ Verbal Prompt ○ Manual/Physical Prompt ○ Dependant	
Ambulation	○ Independent ○ Verbal Prompt ○ Manual/Physical Prompt ○ Dependant	
Daily Chores (Cooking, Cleaning, Making Bed, etc..)	○ Independent ○ Verbal Prompt ○ Manual/Physical Prompt ○ Dependant	
Financial Management	○ Independent ○ Dependant	
Decision Making	○ Independent ○ Verbal Prompt ○ Dependant	
Other:	○ Independent ○ Verbal Prompt ○ Manual/Physical Prompt ○ Dependant	

Is a Recommendation Required
○ Yes ○ No

Recommendations
(NARRATIVE)

Does the individual have/use any Durable Medical Equipment or Adaptive Devices?
○ Yes ○ No

Type of Equipment/Device:
○ Wheelchair
○ Walker
○ Cane
○ Braces
○ Hospital Bed
○ Bedsore Prevention Mattress

- Hoyer Lift
- Helmet
- Bedside Commode
- Prosthesis
- Medical Alert System
- Adaptive Driving Device
- Ramp
- Other:

Is adaptive equipment being utilized effective? Yes No Depends on Situation

A medical equipment prescription is
Available Needed N/A

By Whom? (i.e. Primary physician, Psychiatrist…)
(NARRATIVE)

Is there a recommendation?
Yes No

Recommendations
(NARRATIVE)

11. Psychosocial Assessment: History Of Abuse

History of Abuse

	Yes/No	Perpetrator./Victim	If Yes, Childhood/Adult/On-Going?
Exposure to Trauma?	Yes No	Perpetrator Victim	
History of Sexual Abuse?	Yes No	Perpetrator Victim	
History of Physical Abuse?	Yes No	Perpetrator Victim	
History of Violence?	Yes No	Perpetrator Victim	
History of Neglect?	Yes No	Perpetrator Victim	
History of Bullying	Yes No	Perpetrator Victim	

Other abuse [NARRATIVE]

Is there a recommendation?
Yes No

Recommendation

(NARRATIVE)

12. Psychosocial Assessment: Substance Use

I.

- ○ Substance abuse
- ○ No, individual does not have an SUD
- ○ Not evaluated for SUD (e.g., person is an infant, in crisis situation, etc.)
- ○ Individual has one or more DSM-IV substance use disorder(s), diagnosis codes 291xx, 292xx, 303xx, 304xx, 305xx, with at least one disorder either active or in partial remission (use within past year).
- ○ Individual has one or more DSM-IV substance use disorder(s), diagnosis codes 291xx, 292xx, 303xx, 304xx, 305xx, and all coded substance use disorders are in full remission (no use for one year). This includes cases where the disorder is in full remission and the consumer is on agonist therapy or is in a controlled environment.
- ○ Results from a screening or assessment suggest substance use disorder. This includes indications, provisional diagnoses, or 'rule-out diagnoses.

II. CAGE-AID

Drug and Alcohol Screen

The **CAGE-AID** test is the **CAGE** test **A**ltered to **I**nclude **D**rugs. It employs the same four dichotomous (yes/no) questions with subtle changes to detect drug and/or alcohol abuse or dependence. Quantity and frequency questions can be added to screen for at-risk use. Sensitivity = 79%; Specificity = 77%.

C: *Have you ever felt you ought to **C**ut down on your drinking or drug use?*

○ Yes ○ No

A: *Have people **A**nnoyed you by criticizing your drinking or drug use?*

○ Yes ○ No

G: *Have you ever felt bad or **G**uilty about your drinking or drug use?*

○ Yes ○ No

E: *Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover or negative drug effects?* (**E**ye opener)

○ Yes ○ No

A "yes" answer to any one of these questions is consistent with substance abuse and thus requires further, more detailed assessment.

III. Substance Use Type and Frequency Screen

		Never	1-2	Mo
1.	During the last 12 months, how often did you have 5 or more (males) or 4 or more (females) standard drinks containing any kind of alcohol within a two-hour period?	1	2	
2.	During the last 12 months, how often did you use marijuana (pot, weed, hash, joints, blunts)?	1	2	
3.	During the last 12 months, how often did you use any other drug such as cocaine, speed (amphetamines or methamphetamines), or heroin?	1	2	
4.	During the last 12 months, how often did you use any prescription drugs in order to get high? This could be Vyvanse, Xanax, Valium, Vicodin, Oxycodone, Tylenol-3, Percocet, Ritalin, Adderall, or any other prescription medication.	1	2	
5.	During the last 12 months, how often did you use other things, like whippets, poppers, glue, or over the counter cough or cold medicines, in order to get high?	1	2	

History of mental/emotional, legal, physical, job related, family related consequences. [NARRATIVE]

Has there ever been treatment for alcohol/drugs?
○ Yes ○ No

If Yes
○ Inpatient ○ Outpatient

If yes, when and where were services received and what was the response to treatment?
(NARRATIVE)

Individual's perceptions of the causes for any relapse history. [NARRATIVE]

IV. Other Addictions

Are there any known present/history of other addictions?
○ Yes ○ No
Explain:
(NARRATIVE)

V. Has Individual Attended Any of the Following Self-Help Groups?

☐ AA ☐ NA
Other groups
Explain:

If yes, when and where were groups attended and what was the outcome?
(NARRATIVE)

Is there a recommendation?
○ Yes ○ No

Recommendations
(NARRATIVE)

13. Psychosocial Assessment: Physical Health

Is there a current physical?
○ Yes ○ No
If yes, what is date of physical?_____

Is a physical required?
○ Yes ○ No

If Yes, Explain

Is there a Nursing Assessment?
○ Yes ○ No
If yes, what is date of assessment?_____

Is One Required?
○ Yes ○ No

If Yes, Explain

Does the individual have any physical health problems?
○ Yes ○ No

If Yes, Explain

Is individual receiving care for any health problems?
○ Yes ○ No

Health Conditions

Ability to hear (with hearing appliance normally used)

○ Unreported	○ Adequate—No difficulty in normal conversation, social interaction, listening to TV
○ Minimal difficulty—Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet away)	○ Moderate difficulty—Problem hearing normal conversation, requires quiet setting to hear well
○ Severe difficulty—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)	○ No hearing

Hearing aid used

Yes	No	Unreported

Ability to see in adequate light (with glasses or with other visual appliance normally used)

○ Unreported
○ Adequate—Sees fine detail, including regular print in newspapers/books or small items in pictures
○ Minimal difficulty—Sees large print, but not regular print in newspapers/books or cannot identify large objects in pictures

- Moderate difficulty—Limited vision; not able to see newspaper headlines or small items in pictures, but can identify objects in his/her environment
- Severe difficulty—Object identification in question, but the person's eyes appear to follow objects, or the person sees only light, colors, shapes
- No vision—eyes do not appear to follow objects; absence of sight

Visual appliance used

Yes	No	Unreported

Pneumonia (2 or more times within past 12 months) ? including Aspiration Pneumonia

- Unreported
- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for the condition within the past 12 months
- Information unavailable

Asthma

- Unreported
- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for the condition within the past 12 months
- Information unavailable

Upper Respiratory Infections (3 or more times within past 12 months)

- Unreported
- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for the condition within the past 12 months
- Information unavailable

Gastroesophageal Reflux, or GERD

- Unreported
- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for the condition within the past 12 months
- Information unavailable

Chronic Bowel Impactions

- Unreported
- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for the condition within the past 12 months
- Information unavailable

Seizure disorder or Epilepsy

- Unreported
- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for the condition within the past 12 months and seizure free
- Treated for the condition within the past 12 months, but still experience occasional seizures (less than one per month)
- Treated for the condition within the past 12 months, but still experience frequent seizures
- Information unavailable

Progressive neurological disease, e.g., Alzheimer's

- Unreported
- Not present
- Treated for the condition within the past 12 months
- Information unavailable

Diabetes

- Unreported
- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for the condition within the past 12 months
- Information unavailable

Hypertension

- Unreported
- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for condition within the past 12 months and blood pressure is stable
- Treated for condition within the past 12 months, but blood pressure remains high or unstable

Information is unavailable		

Obesity

Not Present	Medical diagnosis of obesity present or Body Mass Index (BMI) > 30	Unreported

Health Care Provider: (Primary Care Physician, Neurologist, Cardiologist, Endocrinologist, Gerontologist, Dentist etc.)

Name

Address

Phone

City State Zip

Fax

Date Last Seen_____

Next Scheduled Appointment_____

Release of information In chart Signed Refused

Health Care Provider: (Primary Care Physician, Neurologist, Cardiologist, Endocrinologist, Gerontologist, Dentist etc.)

Name

Address

Phone

City State Zip

Fax

Date Last Seen_____

Next Scheduled Appointment_____

Release of information ○ In chart ○ Signed ○ Refused

Health Care Provider: (Primary Care Physician, Neurologist, Cardiologist, Endocrinologist, Gerontologist, Dentist etc.)

Name

Address

Phone

City State Zip

Fax

Date Last Seen_____

Next Scheduled Appointment_____

Release of information ○ In chart ○ Signed ○ Refused

Recommendations
(NARRATIVE)

Does the Individual Have Any Allergies?
○ Yes ○ No

If Yes, Explain

Is there a Recommendation?
○ Yes ○ No

Recommendations
(NARRATIVE)

14. Psychosocial Assessment: Medications

Current Medications
(Include Over the Counter Herbs, Supplements, Home Remedies)

Name	Dosage
Related Diagnosis	Prescriber
How Long?	

Discontinued Medications
(Include Over the Counter Herbs, Supplements, Home Remedies)

Name	Dosage
Related Diagnosis	Prescriber
How Long?	

Major Mental Illness (MMI) Diagnosis

- ○ One or more MMI diagnosis present
- ○ No MMI diagnosis present
- ○ Unreported

Number of anti-psychotic Medications

Number of other psychotropic Medications

SAVE CANCEL

Does the Individual have Any Known Adverse Reactions to Medications, Environmental, or Food?
○ Yes ○ No

If Yes, Explain
(NARRATIVE)

Explain any Treatment/Medication Compliance Issues
(NARRATIVE)

Primary Care Provider

Name	
Address	Relationship
	Phone
City State Zip	Fax

Is there a recommendation?
○ Yes ○ No

Recommendations
(NARRATIVE)

Other Providers: (Psychiatrist, Neurologist, Cardiologist, Dentist …)

Name

Address

City State Zip

Relationship

Phone

Fax

Is there a recommendation?

○ Yes ○ No

Recommendations
(NARRATIVE)

Date of Last Assessment

(Add more specialty doctors involved in individual's care) – REPEAT BOX

○ Add more

15. Psychosocial Assessment: Living Situation

Residential living arrangement

05-Foster family home

Number of licensed beds (for foster home, specialized or general residential home, or institutional setting)

* Select

Individual's Address

Address

City State Zip

Phone

Agency/Provider Name (i.e. foster care agency, SIL provider)

○ N/A

Contact Name

Phone

Provider/Agency Name

Provider/Agency Address

Address

City State Zip

Provider/Agency Phone

Describe the Current Living Situation
(NARRATIVE)

Describe Any Issues in Current Living Situation
Indicate Appropriateness, Mobility, Restrictiveness Accessibility Issues, and Caregiver Concerns
(NARRATIVE)

Is there a recommendation?

○ Yes ○ No

Recommendations
(NARRATIVE)

16. Psychosocial Assessment: Vocational/Educational/ Employment Status

Indicate Vocational/Educational Needs or Barriers.
Indicate the Availability and the Appropriateness of the Program; the Talents, Capabilities, Interests and Future Desires of the Individual. If in Vocational Employment, Indicate Barrier to Employment.
[NARRATIVE]

Education

* Select

School ○
Day Program ○
Employer ○

Address

City State Zip

Contact Individual

Describe Services Received and/or Needed

Is there a Vocational Assessment required?
○ Yes ○ No ○ N/A

Is there a recommendation?
○ Yes ○ No

Recommendations
(NARRATIVE)

17. Psychosocial Assessment: Community Involvement

Wraparound services

○ Yes	○ No	◉ Unspecified

What does the Individual do During the Day?
(NARRATIVE)

Is it in an Integrated Setting or is it a Segregated Setting?
(NARRATIVE)

Does the Individual Do the Following (Either Alone or With Others)?

Go to the Bank?
○ Yes ○ No ○ N/A

Go to the Grocery Shopping?
○ Yes ○ No ○ N/A

Go to the Dollar Store?
○ Yes ○ No ○ N/A

Go to the Mall?
○ Yes ○ No ○ N/A

Go to Restaurants?
○ Yes ○ No ○ N/A

Go to the Doctor?
○ Yes ○ No ○ N/A

Go to the Dentist?
○ Yes ○ No ○ N/A

To the Post Office?
○ Yes ○ No ○ N/A

Go to the Movies?

Other?
○ Yes ○ No ○ N/A
Explain:
(NARRATIVE)

How Is the Individual Involved in their Community?

Explain
(NARRATIVE)

What Activities/Hobbies does the Individual Enjoy?
Explain
(NARRATIVE)

What are the Individual's Likes and Dislikes?
Explain
(NARRATIVE)

Is there a recommendation?

○ Yes ○ No

Recommendations
(NARRATIVE)

18. Psychosocial Assessment: Health And Safety

Are There Any Health and Safety concerns?

In the Home
○ Yes ○ No

In the Community
○ Yes ○ No

At School
○ Yes ○ No

At Work
○ Yes ○ No

Driving
○ Yes ○ No

If yes, a more detailed Safety Assessment should be completed and a Safety Plan should be offered/developed with the individual.

Is there a recommendation?
○ Yes ○ No

Recommendations
(NARRATIVE)

○ Safety Plan Needed (if checked, the Safety Assessment can be completed here)

19. Psychosocial Assessment: Resource Analysis

Resource Analysis

Total annual income

20000.00

Payment source

Employment status

01-Employed full time

Minimum wage

○ Unreported ○ Yes ◉ No ○ Not Applicable

Adoption subsidy

○ Yes ○ No ○ Unreported

Habilitation Waiver

○ Yes ○ No

Is there a recommendation?

○ Yes ○ No

Recommendations
(NARRATIVE)

20. Psychosocial Assessment: Insurance

Types of Insurance and ID Number

Insurance	Yes/No	Number	Plan
Medicaid	○ Yes ○ No		
Medicare	○ Yes ○ No		
Private	○ Yes ○ No		
General Fund Adult:	○ Yes ○ No		
General Fund DD:	○ Yes ○ No		
ABW Basic:	○ Yes ○ No		
ABW Enhanced:	○ Yes ○ No		
Other:	○ Yes ○ No		

Commercial Health Insurance or Service Contract (EAP, HMO)

○ **Yes**

○ **No**

○ **Unreported**

Is there a recommendation?
○ Yes ○ No

Recommendations
(NARRATIVE)

21. Psychosocial Assessment: Transition Planning

Describe the Point at Which Services Would No Longer Be Needed: (Measurable progress to be made or milestones to be met for the consumer to be discharged from care or transitioned to a less intense level of care, or conditions for ongoing maintenance)
(NARRATIVE)

22. Psychosocial Assessment: Recommendations

Built From the Recommendation, Plan Items and the Interpretive Summary or Diagnostic Formulation

- **Support Circle**
- **Cultural, Spiritual, or Religious Values**
- **Legal Involvement**
- **Emotional/Behavioral/Clinical/Therapeutic**
- **Durable Medical Equipment or Adaptive Devices**
- **Activities of Daily Living**
- **Abuse**
- **Addictions**
- **Physical Health**
- **Medical Specialty**
- **Living Situation**
- **Vocational/ Educational/Employment Status**
- **Community Involvement**
- **Health and Safety**
- **Resource Analysis Insurance**
- **Transition Planning**

23. Psychosocial Assessment: Diagnosis Determined

Diagnosis

	ICD-9	DSM-IV	Description	Rule Out
AXIS I	Pri			☐
	Sec			☐
	Ter			☐
	Substance Abuse Diagnosis			History
	Pri			☐
	Specifier			
	Sec			☐
	Specifier			
AXIS II	Pri			☐
	Sec			☐
AXIS III	Pri			
	Sec			
	Ter			

AXIS IV	☑ Economic problems	☑ Problem with primary support group
	☑ Problem accessing healthcare	☑ Educational problems
	☑ Problem related to social environment	☐ Problem related to interaction with legal system
	☑ Occupational problems	☐ Other psychological and environmental problems
	☑ Housing problems	☐ Behavioral/Individually problems

	Current GAF	Date
AXIS V	50	01/11/2011

Diagnostic Summary	Diagnostic summary for John Doe
Diagnosis Made By	Test User

History of Diagnosis lookup

Staff Signed By Signature Date

Supervisor Signature Required By

24. Psychosocial Assessment: Diagnosis to be Determined Following Additional Assessment

Additional Assessment Needed:

○ BEHAVIORAL ASSESSMENT ○ HEARING ○ SPEECH ○ VISION ○ MEDICAL
○ NEUROLOGICAL ○ OTHER