INITIAL PSYCHOSOCIAL ASSESSMENT

PRIMARY CAREGIVER INFORMATION

Name ______________________ Relationship to Patient ______________________

Address ______________________ Health Status ______________________

City/State/ZIP ______________________

Phone No. (________) ______________________

Age ________ ❑ Male ❑ Female

SOCIAL HISTORY ASSESSMENT

Family System Background (General History) ______________________

Family Stability ______________________

Caregivers and Supporters (in Addition to Primary Caregiver) ______________________

Members of Immediate Family/Significant Others Living with Patient

Members of Immediate Family/Significant Others NOT Living with Patient

Patient's Most Significant Relationship ______________________

Length of Relationship ______________________

Patient's Educational History (Indicate Number of Years Completed)

Elementary ________ Jr. High/Middle School ________ High School ________ College ________ Vocational ________

Patient's Occupational History ______________________

Ethnic and Cultural Considerations ______________________

Significant Losses/Crises Experienced with Family or Other Significant Others ______________________

PATIENT NAME–Last, First, Middle Initial	ID#

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SUPPORT SYSTEM ASSESSMENT

Discuss the questions listed below with the patient and family. Summarize their responses in the space provided.

What has this experience been like for you? Do(es) family/patient talk about illness with you? How is that for you?

Patient: ______

Family: ______

Have there been changes in the roles of members of your family? Changes in family plans/routines?

Patient: ______

Family: ______

What are the reactions to increased dependency?

Patient: ______

Family: ______

Who/what in your community can you count on in hard times?

______

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PHYSICAL RESOURCE ASSESSMENT

Environmental Factors ______

Source and Adequacy of Income ______

Other Financial Factors ______

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RISK ASSESSMENT

RISK ASSESSMENT ELEMENTS			NAME OF PERSON ASSESSED			
Risk Factor	**Levels**	**Score**	**Patient**			
FAMILY (Select all that apply)	Lives Alone	1				
	Separated/Divorced/Discord	2				
	Parent(s) - Still Living	1				
	Dependent Family Members (disabled/elderly/sick)	2				
	Minor Children	2				
RELATIONSHIPS (Select one)	Close/Intimate/Open Communication	1				
	Supportive/Lives Close	2				
	Supportive/Lives Distant	3				
	Not Close/Rare/Occasional	4				
	Estranged/Disruptive	5				
SELF REPROACH/GUILT HOPELESSNESS/ SELF-BLAME (Select one)	None - Coping Well	1				
	Mild - Expresses Concern	2				
	Moderate - Frustration/Anger	3				
	Severe - No Coping/Bitterness	4				
	Extreme - Suicidal/Aggressive	5				
ADDITIONAL RISK FACTORS (Select all that apply)	Recent (< 2 mo) Diagnosis	2				
	Financial/Legal Issues	2				
	Other Recent (12 mo) Losses	3				
	Mental Health History/Active	4				
	Alcohol/Substance Abuse	5				
		TOTAL SCORE				
		BEREAVEMENT RISK LEVEL (Mild/Moderate/High):				

MILD RISK = 10 OR LESS MODERATE RISK = 11 TO 19 HIGH RISK = 20 OR MORE

SERVICE NEEDS

Does the patient need assistance in any of the areas listed below?

	YES	NO	TYPE OF ASSISTANCE/REFERRAL NEEDED
Budget Counseling			
Other Financial Need			
Social Services			
Funeral Arrangements			
Legal Will Preparation			

EMOTIONAL ASSESSMENT

Is the patient exhibiting or experiencing the following?

	YES	NO		YES	NO		YES	NO
Memory Problems			Withdrawal			Feelings of: Loneliness		
Changes in Sleep Patterns			Hostility			Isolation		
Anxiety			Anger			Guilt		
Alertness			Irritability			Moodiness		
Lethargy			Depression			Hallucinations		

Does the patient have impaired comprehension, judgment, or reasoning? ❑ Yes (If yes, explain) ❑ No

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COMMENTS ON PATIENT/FAMILY RISK POTENTIAL AND EMOTIONAL STATUS

(Discuss risk potential of patient/family and the primary problems observed. Include family dynamics, present and anticipated coping, support systems, etc. Also include grief potential within the family and any factors that would influence the intensity or level of grief.)

ASSESSMENT SUMMARY AND PLAN

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Signature and Title of Assessor ______________________________ Date ____/____/____