Comprehensive Psychosocial Assessment

Identifying Information:

Date of Assessment: _____

Patient Name: _____ Medical Rec #: _____

Gender: ❑ Male ❑ Female Age / DOB: _____ Marital Status: _____

Race / Ethnicity: _____ Language Spoken: _____

Source(s) of Assessment Data: _____ Highest Education Level: _____

Living Arrangements (who does patient live with?): _____

Employment Status and History: _____

Presenting Problem:

_____

_____

General Description of Patient:

_____

_____

Signs and Symptoms Observed or Reported (select all that apply):

- ❑ Anxious
- ❑ Depressed
- ❑ Tearful
- ❑ Flat affect
- ❑ Forgetful
- ❑ Confused
- ❑ Delusional
- ❑ Hallucinations
- ❑ Restless
- ❑ Irritable
- ❑ Anger
- ❑ Aggression
- ❑ Denial
- ❑ Withdrawal
- ❑ Excessive fear or worry
- ❑ Excessive Guilt
- ❑ Increased appetite
- ❑ Decreased appetite
- ❑ Decreased energy / lethargy
- ❑ Poor ability to concentrate
- ❑ Impaired judgment or reasoning
- ❑ Insomnia
- ❑ Hypersomnia
- ❑ Poor hygiene
- ❑ Abuse or neglect
- ❑ Suicidal ideations
- ❑ Other:_____
- ❑ Other:_____
- ❑ Other:_____
- ❑ Other:_____

Financial Assessment:

1. Which statement below best describes your current financial situation:

- ❑ I have no financial concerns
- ❑ I have a few financial concerns
- ❑ I have major financial concerns but am able to manage them
- ❑ I have major financial concerns and am having trouble managing them
- ❑ I have difficulty meeting my basic needs due to my financial situation

2. In which of the following areas are you currently having financial difficulties?

- ❑ None
- ❑ Paying my rent or mortgage
- ❑ Maintaining my home
- ❑ Transportation or buying gas
- ❑ Paying for medications
- ❑ Paying my insurance premiums or deductibles
- ❑ Being able to afford doing things I enjoy
- ❑ Paying for food
- ❑ Paying for utilities
- ❑ Paying for clothing
- ❑ Paying heath care bills
- ❑ Paying my insurance premiums
- ❑ Other: _____
- ❑ Other: _____

3. During the past 6 months, describe any prescription medications that you did not take or get filled because you felt you couldn't afford them.

_____
_____
_____
_____

Family Assessment:

4. In thinking about your family or caregivers in your home over the recent past, has anyone:

Experienced periods of excessive worry, fear or anxiety?	❑ Yes	❑ No
Experienced periods of excessive sadness or depression?	❑ Yes	❑ No
Used alcohol or other substances excessively or to help deal with a difficult situation?	❑ Yes	❑ No
Had difficulty focusing or concentrating?	❑ Yes	❑ No
Got into a heated argument?	❑ Yes	❑ No
Used hurtful language against another person?	❑ Yes	❑ No
Physically injured another person?	❑ Yes	❑ No
Been diagnosed with a serious medical condition?	❑ Yes	❑ No
Undergone a major change?	❑ Yes	❑ No
Suffered an important loss?	❑ Yes	❑ No

Provide more details about "Yes" responses:

5. Who are the people that provide you with the most comfort and support?

6. How has your illness affected you and your family or caregivers?

7. In what ways do you talk about your illness with your family or caregivers:

8. Discuss any concerns you have with family relationships:

9. Describe any cultural or ethnic beliefs or traditions that play a role in your health or the care you receive:

Housing and Safety Assessment:

10. Identified housing risks (select all that apply):

- ❑ None
- ❑ Structural deficits
- ❑ Cleanliness or hygiene concerns
- ❑ Cluttered or unsafe walkways or stairs
- ❑ Bedding concerns (e.g., poor mattress, bed bugs)
- ❑ Pest infestation (e.g., insects, rodents)
- ❑ Unsafe or absent heating source
- ❑ Unsafe or absent cooling source
- ❑ Unsafe electrical outlets or cords
- ❑ Indoor quality concerns (e.g., lead, mold, asbestos)
- ❑ Unsafe or absent kitchen appliances
- ❑ Unsafe or absent lighting
- ❑ Absent telephone or mobile phone
- ❑ Unsafe or absent door and/or window locks
- ❑ Ineffective or absent plumbing
- ❑ Unsafe or absent water source
- ❑ Unsafe or uncared for pets
- ❑ Absence of smoke alarms or fire extinguishers
- ❑ Unsafe tobacco use
- ❑ Dementia safety or wandering concerns
- ❑ Child safety concerns
- ❑ Exterior concerns
- ❑ Other: _____
- ❑ Other: _____

11. Which of the following best describes your needs when you need to use the bathroom at night?

- ❑ I walk independently and do not require any aids to get to or use the bathroom.
- ❑ I can walk alone to the bathroom but must use an aid, like a cane, walker or a need to hold on to the walls.
- ❑ I can only walk to the bathroom with the assistance of another person.
- ❑ I cannot walk to the bathroom at night and use a bedside commode or urinal independently.
- ❑ I cannot walk to the bathroom at night and need help to use a bedside commode or urinal.
- ❑ I cannot walk to the bathroom at night and depend on incontinence pads or briefs.

12. Describe any time in the past year that you fell at home:

_____
_____
_____
_____

13. Describe other identified risk factors for falls (e.g., confusion, multiple medications, weakness, etc.):

_____
_____
_____
_____

14. Based on the housing and safety assessment, what is the overall fall risk for the patient?

- ❑ There is little or no fall risk
- ❑ There is a mild to moderate fall risk
- ❑ There is a moderate to high fall risk
- ❑ There is a high fall risk with a history of past falls

Patient Assessment:

15. What is the most stressful thing in your life right now?

16. Were there any unusual or traumatic experiences for you as a child? If so, describe:

17. Have you ever attempted suicide or made plans to commit suicide?

18. Have you ever been treated for depression, anxiety or another mental health issue? If so, describe:

19. Describe your current and past use of or experience with addictive substances and/or behaviors, such as alcohol, tobacco, habit-forming drugs, gambling, pornography, etc.

A. Do you see your current use as a problem?

20. Describe any changes in your eating habits within in the past year:

A. Have you had a weight change of more than 10 pounds in the past year?

B. Do you ever binge eat or induce vomiting after eating?

C. Describe any use of diet medications, laxatives or water pills to manage your weight:

21. Describe how your illness or current situation has impacted your physical or sexual relationships:

22. Describe any legal concerns you're facing (e.g., durable power of attorney, arrests, convictions, lawsuits, bankruptcy, etc.):

23. Describe the role of religion and spirituality in your life and how you express it?

24. Describe any religious or spiritual beliefs that may impact your medical decisions?

25. Describe your fears about suffering and dying?

26. Describe the hobbies or activities that give you the most pleasure:

27. How have you made it through difficult times in the past?

28. What resources to support you at this time can I help you obtain?

Psychosocial Risk Factors (Mark all that apply):

- ❑ Progressive or chronic diagnosis
- ❑ Terminal diagnosis
- ❑ New onset or progressing dementia
- ❑ New loss of functioning
- ❑ Increased dependence on ADLs
- ❑ Nutritional deficits
- ❑ Alteration in body image
- ❑ Chronic pain
- ❑ High symptom burden
- ❑ Recent personal loss
- ❑ Significant personal or family change
- ❑ No or few caregiving resources
- ❑ Poor family dynamics or coping
- ❑ Marital issues
- ❑ Family history mental / behavioral illness
- ❑ Dependent children or family members
- ❑ Illness or death impacts family financial and social survival
- ❑ Poor communication skills between patient and family
- ❑ Substance abuse
- ❑ Substance abuse in caregiver
- ❑ Actual or suspected abuse or neglect
- ❑ Safety concerns
- ❑ Insufficient financial resources
- ❑ Unemployment or work issues
- ❑ Poor or deteriorating housing
- ❑ Suicide attempt or risk

Other psychosocial risk factors noted:

Psychosocial Needs:

Based on the comprehensive psychosocial assessment, the patient and family have the following needs (select all that apply):

		Details of Needs or Type of Referral
Financial Counseling	❑ Yes ❑ No	
Insurance Support	❑ Yes ❑ No	
Medication Assistance	❑ Yes ❑ No	
Medical Equipment or Supplies	❑ Yes ❑ No	
Personal / Behavioral Counseling	❑ Yes ❑ No	
Dementia or Behavioral Counseling	❑ Yes ❑ No	
Family Counseling	❑ Yes ❑ No	
Short-term Caregiver Counseling	❑ Yes ❑ No	
Addressing Issues with Noncompliance	❑ Yes ❑ No	
Addressing Issues with Substance Abuse	❑ Yes ❑ No	
Adjustment to Illness	❑ Yes ❑ No	
Decision-making Support	❑ Yes ❑ No	
Community Resource Needs	❑ Yes ❑ No	
Nutritional or Meal Support	❑ Yes ❑ No	
Transportation Services	❑ Yes ❑ No	
Housing Support	❑ Yes ❑ No	
Home or Personal Safety Support	❑ Yes ❑ No	
Adult or Child Protective Services	❑ Yes ❑ No	
Caregiving Assistance	❑ Yes ❑ No	
Legal Support	❑ Yes ❑ No	
Support Developing Advance Directives	❑ Yes ❑ No	
Cultural, Religious or Language Support	❑ Yes ❑ No	
Spiritual Counseling	❑ Yes ❑ No	

		Details of Needs or Type of Referral
Hospice Services	❑ Yes ❑ No	
Respite Services	❑ Yes ❑ No	
Medical Day Care Services	❑ Yes ❑ No	
Private Duty Services	❑ Yes ❑ No	
Outpatient Services	❑ Yes ❑ No	
Alternate Placement (e.g., ALF, SNF)	❑ Yes ❑ No	
Bereavement Counseling	❑ Yes ❑ No	
Funeral Arrangements	❑ Yes ❑ No	
Other:	❑ Yes ❑ No	
Other:	❑ Yes ❑ No	
Other:	❑ Yes ❑ No	

Other Assessment Details:

Name / Title: _____ Signature: _____ Date: _____