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#

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?

RISK ASSESSMENT

Check the appropriate response for each question below. A "yes" response indicates a risk potential.

	PATIENT			PRIMARY CAREGIVER		
	YES	NO	Uncertain	YES	NO	Uncertain
Are there children/adolescents in immediate family?						
Are there dependent family members (handicapped, elderly, sick)?						
Is a parent still alive?						
Will death result in loss of financial provision?						
Will death mean loss of constant companion/emotional support?						
Will death mean loss of home (feared or actual)?						
Does the family have difficulty making decisions?						
Is family unable to share feelings?						
Is there reluctance to face facts of illness?						
Is there marital or family discord?						
Are there communication difficulties in the family?						
Is there a concurrent life crisis?						
Has there been difficulty in dealing with previous losses?						
Is the family inflexible?						
Has the patient or family members had excessive or prolonged emotional problems/mental illness?						
Is there a lack of community support?						

PHYSICAL RESOURCE ASSESSMENT

Environmental Factors _____

Source and Adequacy of Income _____

Other Financial Factors _____

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

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

Signature and Title of Assessor _____ **Date** ____/____/____