Patient Name: _____

Patient DOB: _____

SOCIAL/COMMUNITY SUPPORTS

Who do you live with? _____

Y N Positive living environment
Y N Positive relationships with friends/family
Y N Spiritual life/religious practice/church affiliation
Y N Hobbies/leisure activities

BASIC NEEDS

Y N Homeless or soon to be evicted
Y N Safe and sanitary dwelling
Y N Utilities connected
Y N Adequate food
Y N Adequate clothing
Y N Adequate transportation

LEGAL HISTORY

Y N Legal resources needed
Y N Currently on probation/parole
Y N Outstanding warrants
Y N Previous felony conviction

ECONOMIC STATUS

Y N Currently employed
Y N Adequate income
Y N Outstanding debt
Y N Adequate budgeting
Y N Receives public benefits
Y N Receives/pays child support

EDUCATIONAL NEEDS

Y N Limited or incomplete education
Y N Language or literacy barriers
Y N History of special education
Y N Further education/training desired

BEHAVIORAL HEALH/SUBSTANCE ABUSE

Y N Mental Health Concerns
Y N Drug, Alcohol Use/Abuse
Y N Tobacco Use

SEXUAL/REPRODUCTIVE HEALH

Y N Parent? (natural, foster, adopted, step)
Y N Satisfactory parenting experience
Y N Adolescent parent
Y N Paternity issues
Y N Need for parenting support/education
Y N Understands/practices safer sex
Y N Understands/participates in HIV testing
Y N Understands/practices birth control
Y N Incest or rape victim

MEDICAL/HEALTH CARE NEEDS

Y N Understands diagnoses
Y N Understands treatment plan
Y N Compliant w/ meds/medical regime
Y N Has necessary medication, supplies, equipment, services *(DME, ramps, grab bars, medical alert bracelet, lifelines, home health services).*
Y N Access to further health care *(outside KC Free –TMC, etc)*
Y N Eligible for insurance, Medicaid, Medicare
Y N Eligible for SSI, SSDI
Y N Hearing, vision, speech needs
Y N Interpreter required
Y N Special accommodations needed
Y N Exercises regularly/eats healthy foods
Y N Desires exercise/nutrition support/resources

INTIMATE PARTNER VIOLENCE

Y N Are you in a situation where your current or former partner (boyfriend, girlfriend, spouse) is calling you names or has treated you in ways that makes you feel uncomfortable or afraid?
Y N Have you recently been pushed, hit, kicked, punched, strangled, threatened, or hurt by your current or former partner (boyfriend, girlfriend, spouse, family member, caregiver)?
Y N Would you like some written information for yourself or someone you know who is experiencing domestic violence?

Assessment Completed By: _____ Date Completed: _____

Patient Name: _____
Patient DOB: _____

PSYCHOSOCIAL ASSESSMENT SUMMARY:

PLAN:

Assessment Completed BY: _____ Date Completed: _____