Psychosocial Assessment Outline

Identifying Data:

- Basic demographic information disguised for confidentiality
  (*Ex:. S is a 28 yr. old Caucasian, single mother of 3 children – 2 in foster care. She has been living in a women's residential program with her youngest child since ___. She has ongoing involvement with this agency and with DSS.) (Ex: Josh is a 7 yr old 2nd grader at ___ Elementary School. He is the youngest of 3 children and lives with both parents in a middle class community. This is his first contact with social services.)*

Referral Source and Presenting Problem:

- How was the client referred? Who is requesting help and for what problem? Is the client voluntary or involuntary? Who provided this information (client, family, agency records?)
- Using the client's or informant's own words, what is the problem, or reason for seeking services?

Description of Presenting Problem:

- Clear description of issue, behavior or symptoms, length of time problem has been present.
- Why is the client seeking help or being referred now? Try to separate the current problem or episode from past history or problems.
- What events or stressors or losses have led to the current request for help? If no clear precipitant. If no clear precipitant, are the problems recent or long-term?
- For referrals geared toward developmental interventions or risk prevention (such as social skills groups or psycho-education for substance abuse) include which risk factors and/or developmental stages/vulnerabilities are being addressed by the referral for service.
- Make a brief statement about prior use of social services, length of treatment, hospitalizations, medications, etc.
- Current functioning, social supports: Access to, or lack of, family, other care givers; functioning level at work or school.

Relevant Past and Social History:

- Describe prior functioning (the baseline or period of best functioning) before the onset of current problems. Prior coping or areas of mastery (school, work history, friends).
- Summarize past problems or treatment history.
- Include history of trauma, losses.
- History of medical problems, substance use, legal issues.
- Relevant early family or developmental events.

Observational Assessment (What You Observe):

- Description of the client's appearance and behavior during the assessment period. (Ex: observed behavior, level of cooperation. Ability to relate to interviewer. Any symptoms or unusual behavior during the initial assessment period.
- A formal mental status may be used in some agencies. (Describes mood and affect, level of coherent thinking or speech, delusional thinking, hallucinations, cognitive functioning, suicidal or homicidal thinking.)

Formulation – Your Impressions: (This will provide support for your intervention plan).

- Start with restating key identifying information, presenting problem and referral source.
- Present your understanding of the problem, the causes, and your analysis of the most important factors affecting the problem.
- Your impressions of the client's ability to use help, move toward change – what are the client's strengths, protective factors or risk factors affecting capacity for change.

Treatment or Intervention Plan:

- Describe in a brief narrative format your intervention