Universal Mental Health & Substance Abuse
Psychosocial Assessment

Agency_____

Address_____

Phone_____

Client Name_____ Date: _____
Social Security #_____ DOB: _____
Client's Legal Status: _____
Legal Guardian Name: _____ Phone: _____
Relationship to Client: _____
Emergency Contact: _____
Phone number: _____ Relationship to you: _____

1. What brings you to this agency?

_____

2. What would you like to accomplish? _____

_____

3. What resources and strengths do you have that will help you accomplish your goals?

_____

I. Current Living Situation

A. Where are you living? _____

B. Are you having any difficulties with your living situation? _____

_____

II. Finances

A. Current Income: _____ ___Wages ___SSI ___SSDI ___VA benefits ___Other

___ Food Stamps ___Medicaid ___Medicare ___Payee

B. Recent Changes: _____

III. Physical Health

A. Is there anything about your health that worries you? _____
B. Primary Care Provider: _____
C. Date of Last Physical: _____
D. Allergies to medications, food or the environment? _____

E. Nutritional Needs: _____
F. Medications (route / dosage/schedule) (start and end dates) (prescribing Physician):

_____

_____

Non- Prescription Medications and Medications not listed: _____

_____

G. Physical and environmental barriers that may impede ability to obtain services: _____

_____

H. Need for cognitive or neurological assessment? _____

_____

IV. Educational/Vocational

A. Previous Education/training (highest grade completed- college/trade, employment and military history: _____

_____

B. School performance / Military Discharge _____

_____

C. Current and Last position held: _____

D. What are your interests in the areas of work or education: _____

_____

V. Legal

A. On Probation: _____ Probation Officer: _____

B. Pending Charges: _____

C. Legal History: _____

_____

D. Were you under the influence of alcohol or drugs at the time you committed this offense(s)? _____

_____

E. How many crimes in your life were committed while under the influence of substances or in order to buy substances? _____

_____

VI. Social System

A. Client's current family composition: _____

B. Current support/social relationship(s): _____

_____

C. Significant Relationship History: _____

_____

D. Are you involved with an ethnic/cultural or religious/spiritual community? _____

_____

E. Social/ Environmental/ Recreational/Hobbies/ Interest Needs: _____

_____

VII. Family History

NAME OR INITIALS/ AGES	TYPE OF RELATIONSHIP SUPPORTIVE OR NOT/CONTACT OR NOT	HEALTH HX INCLUDING MENTAL HEALTH AND ADDICTIVE DISORDERS
Parents:		
Grandparents:		
Extended Family:		
Siblings:		
Children:		
Family Relationships:		

Current significant relationship (Quality of relationship/Does partner struggle with mental health and/or addictive disorders)? _____

_____

VIII: Personal History

A. Developmental History

Where were you born and where did you grow up? _____

Family composition, birth order: _____

_____

Divorces, separations, loss, deaths: _____

Family Strengths and/or weaknesses: _____

1. Childhood (Schools, friends, family, significant events) _____

_____

2. Adolescence (School, social events, family, friends, significant events) _____

_____

3. Adulthood (Education, Vocation, Relationships, Marriage, children, significant events)

_____

_____

B. History of Trauma, Violence, Abuse, Neglect

Has anyone ever hurt you, tried to control you by threatening or tried to restrict your freedom? Yes_____ No_____

How_____

Have you ever hurt anyone, damaged property, tried to control someone by threatening or restricting his or her freedom or thought about it? Yes_____ No_____

How_____

Have you ever hurt yourself or thought about it? Yes_____ No_____

How? _____

Have you ever hurt or thought about hurting an animal? Yes____ No_____

How? _____

Current concerns, thoughts, plans, intentions in any of the above? _____

Have you ever witnessed a violent crime or tragic accident? Yes_____ No_____

Have you ever been involved in an accident or been traumatized physically, emotionally or sexually? Yes____ No_____

_____

_____

C. Functioning and Coping Patterns

Can you remember a time in your life when things were going well for you? _____

_____

What was going on at that time? _____

_____

What has changed? _____

_____

D. Current Overall Functioning

Appetite: No change___ Decrease___ Increase___ Other_____
____Restricted ____Binging/Purging

Weight: Stable___ Increase___ Decrease___ Other_____

Elimination: No Change____ Alteration_____

Alteration, explain: _____

Average # Sleep Hrs: _____ _____Trouble staying asleep ____Sleeping less
___Sleep/Rest problems ____Early awake ____Sleeping more ___Disturbed sleep ___ Nightmares
___Trouble Falling asleep ____Night sweats

___Uses sleep aids Sleep aid_____

Hygiene: Good____ Poor____ Changed_____

Energy: Increased____ Decreased____ No Change____
Interest: Increased____ Decreased____ No Change____
Sex: Increased____ Decreased____ No Change____
Socialization: Increased____ Decreased____ No Change____
Decision Making: Easy_____ Slowed_____ Change_____
Thinking: Easy_____ Slowed_____ Change_____

E. Psychiatric/ Mental Health History

1. Have you ever received a mental health diagnosis in the past?

Describe: _____

Have you ever attempted suicide? _____

How many times? _____ How did you attempt?_____

Last attempt? ____ Have you ever known anyone who attempted suicide? Yes__ No__

Who? _____ When? _____

How? _____Comments_____

_____

2. What mental health services have you received? (Counseling, crisis services, hospitalizations, medications, friends, church) _____

_____

3. What mental health services were for you? _____

4. What part of the treatment was helpful? _____

5. Is there something you learned in treatment that helps you today? _____

_____

5. What was not helpful? _____

6. Do you find your symptoms are affected by the seasons? _____

_____

7. When was the first time you remember being impacted by your symptoms, please describe _____

_____

F. Substance Abuse/Dependence

How has the use of cigarettes, alcohol or drugs affected how you handle things? _____

_____

What substance(s) have you or do you struggle with? _____

SUBSTANCE	AGE OF FIRST USE	DATE OF LAST USE	ROUTE OF ADMIN	PATTERN HOW MUCH -OFTEN
Alcohol				
Heroin				
Methadone				
Other Opiates				
Barbiturates				
Other sed/hyp/tranq:				
Cocaine				
Amphetamines				
Cannabis				
Hallucinogens				
Inhalants				
Caffeine				
Nicotine				
Other				

Have you experienced "black outs" as a result of substance intoxication? __Yes __No
Have you experienced physical withdrawal from substances? ____Yes ____No
Have you experienced seizures during physical withdrawal? ____Yes ____No
Have you overdosed on drugs? ____Yes ____No
Have you attempted to cut down or cease use in the past? ____Yes ____No
Have others annoyed you when asking about your drinking or substance use? _Yes _No
Have you ever felt guilty about your substance use? ____Yes ____No
Have you ever had an eye-opener or used first thing in the morning due to a hangover or withdrawal? ____Yes ____No
Have you ever been to detox? Where? How many times? _____

_____

How do you feel your substance use impacts your mental health? _____

_____

Are you or have you ever been involved in any current substance abuse treatment? (Outpatient, Residential, Intensive Outpatient, DSAT, Inpatient, Partial, DEEP) Where and when?

_____

Which treatment was most helpful? _____

What specifically was helpful and what do you still use as a tool of support? _____

_____

What was not helpful? _____

Describe your longest period of sobriety_____

_____

How did you stay sober? _____

Did you notice a difference in your mental health when you were using and when you were sober? What was the difference? _____

_____

How has your use and/or history of your use impacted your family and your relationships? _____

_____

Have you ever been involved with a Self-Help/12-step Program/Dual Recovery Anonymous? Was it helpful?

_____

Other Addictive Behaviors (gambling, sex, relationships, shopping, stealing, food, lying, violence, risky behaviors):

_____

Client's Self Assessment

Do you have a problem with alcohol or drugs interfering in your life? _____

Are you concerned about your substance use or addictive behaviors? _____

Do you have concerns that your mental health is impacting the quality of your life (depression, anxiety, anger, inability to focus)? _____

How confident are you about making changes in your drugs/alcohol use or in maintaining the changes you have already made? _____

How confident are you about making changes in your life to improve your mental health?
_____

Do you think changing your current level of drug or alcohol use is possible?
_____

Do you think it is possible to make changes to improve your mental health?

_____

How are you coping in your life today? (Scale of 1-10 with 10 meaning the best you've ever been)
_____

Do you think you need to make changes? _____

What is your motivation for seeking assistance now? _____

_____

What do you think might happen if you don't change (consequences)? _____

_____

What do you think is the first step you can do to begin change in your life? _____

_____

_____

IX. Mental Status

APPEARANCE
Stated age_____ Younger____ Older_____ Appropriate____ Inappropriate____
Unkempt_____ Neat____ Disheveled____ Other_____

BEHAVIOR/ATTENTION
Cooperative_____ Sleepy/lethargic____ Unremarkable___ Passive___ Guarded___
Distracted___ Suspicious___ Restless/Agitated___ Uncooperative___ Hostile_____
Sober____Focused____Withdrawn____Bored____Engaged____Tearful___Hyperactive____
Defiant___ Oppositional___ Hostile___ Lethargic___ Anxious____ Able to follow directions____

CLOTHING
Appropriate _____ Inappropriate_____

Describe: _____

EYE CONTACT
Good___ Intermittent____ Little____ None_____

MOTOR ACTIVITY
Avoids eye contact_____ Makes eye contact_____ Passive_____ Posturing_____
Restless_____Responsive_____Slowed_____Spontaneous_____
Tics_____ Tremors_____ WNL_____ Other_____

ATTENTION
Alert/Attentive_____ Apathetic_____ Distracted____ Drowsy____ Hypervigilent_____
Other_____

Describe: _____

AFFECT (OBSERVED)
Appropriate/Congruent_____ Full range_____ Blunted_____ Broad_____ Labile____
Constricted_____Flat_____Grandiose_____Inappropriate/Incongruent_____

MOOD (BY REPORT)
Anxious____ Dysphoric ____ Elevated ____ Euphoric____ Euthymic (WNL)_____
Angry____ Agitated____ Sad___ Normal_____ Irritable____

SPEECH (RATE, FLOW, VOLUME)
Difficult to interrupt_____ Hesitant____ Loud____ Pressured____ Rambling_____
Rapid___ Slow____ Soft___ Slurred_____ Normal_____ WNL____

Describe: _____

STREAM OF THOUGHT/ASSOCIATION
Unremarkable____ Logical____ Blocking____ Relevent____ Flight of ideas____ Goal Directed____
Coherent___Circumstantial___Incoherent____Tangential_____Evasive___ Looseness of Assoc._____
Distraction_____

THOUGHT PROCESS (BY REPORT)
Obsessional _____ Projection____ Ruminative____ Thought insertion_____ Other ____

THOUGHT CONTENT
Appropriate_____ Bizarre Ideation _____ Delusional _____ Grandiose ____ Homicidal___
Ideas of reference ___Depersonalization _____ Obsessive/Compulsiveness_____
Paranoid____Poverty____Somatic____Suicidal_____WNL___Other_____

HALLUCINATIONS/DELUSIONS
Delusions: Somatic _____ Persecutory_____
Hallucinations: Auditory_____Visual_____Olfactory_____Tactile_____
Other: _____

INTELLECTUAL FUNCTIONING
Above average_____ Average ____ Below Average _____Learning Disabled____
Street Smart_____

ORIENTATION
Confused_____ Disorientated ___ Person ___ Place ___ Time ___Other___

MEMORY (BY REPORT)
Impaired-Recent____ Impaired-Remote____ Intact-Recent___ Intact-Remote____

INSIGHT
Absent___ Externalizes___ Full___ Limited ___ Internalizes___ Other____

JUDGMENT
Fair___ Good ___ Poor___

X. Summary of Services Needed

Housing___ Legal___ Trauma History___ Financial Resources___ Support System____

Mental Health_____Health Needs____ Family___ Substance Abuse___ Co-occurring Services_____

Voc/Education_____Personal___ Crisis Support____

Describe any unmet needs: _____

_____

XI. Summary of Clients Strengths and Barriers

Strengths: _____

Barriers: _____

Presenting Stage of Change:
Precontemplation ___ Contemplation ___ Preparation ___ Action ___ Maintenance ___ Relapse ___

Client's
motivation_____

Presenting Clinical Issues/Problem list (What's important for client, interaction between substance use, mental health when applicable):

Clinical Formulation: Assessment Summary by ASAM Dimension

Alcohol Intoxication and/or withdrawal Potential	__Very high-risk	__High-risk	___Moderate risk	__Low
Biomedical conditions and complications	__Very high-risk	__High-risk	___Moderate risk	__Low
Emotional, behavioral conditions/complications	__Very high-risk	__High-risk	___Moderate risk	__Low
Readiness to change	__ Very high-risk	__High-risk	___Moderate risk	__Low
Relapse, cont. use or cont. problem potential	__Very high-risk	__High-risk	___Moderate risk	__Low
Recovery Environment	__Very high-risk	__High-risk	___Moderate risk	__Low

Clinical Summary/Formulation (Brief integration of assessment and next steps based on all info gathered):

Universal Mental Health & Substance Abuse
Psychosocial Assessment

Diagnosis

AXIS
I_____**by**_____

AXIS
II_____**by**_____

AXIS
III_____**by**_____

AXIS
IV_____**by**_____

AXIS
V_____**by**_____

Recommended Level of Care/ Treatment recommendations/Time available/Plan Summary

_____

_____

_____

_____

_____

_____

_____ _____
Clinician **Credentials** **Date**

_____ _____
Supervisor **Credentials** **Date**

Annual Update: _____ _____
Clinician Date

Update
Notes_____
_____

_____ _____
Clinician **Credentials** **Date**

Agency: _____
Address: _____
Phone: _____