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# Member Psych-Social Assessment

A psychosocial assessment is an evaluation of an individual's mental health and social well-being. The goal of this assessment is to provide the members with the best care possible while helping to improve their health.

Name _____ DOB _____

SS# _____

Health Insurance _____ Health insurance # _____

Address _____

_____

Phone Number _____

Email _____

Place of Birth _____

Ethnicity _____ Religion _____

Languages _____ Marital Status _____

Responsible Person _____

Guardian _____

Translator _____

## Emergency Contact Information

Name _____

Relationship _____

Phone number _____

Responsible Person _____

Guardian _____

Translator _____

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## Community & Social Services

Pharmacy Name _____

Pharmacy Number _____

VNA _____

VNA Number _____

DDS/DMH _____

DDS/DMH phone number _____

## Any other Programs or Services:

PCA ADH GAFC SHC

Contact Information

_____

_____

Any other services or support being received may result in a duplication of services. Failure to report additional services or support may result in money owed to the AFC provider.

Referral Sourcec_____

Reason for AFC Enrollment

_____

_____

Fee Status:

PVT _____ Medicaid _____ SCO _____

OneCare _____ Other _____

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1. **Birth & Developmental History: (if Relevant)**

Where there any significant event or events in your childhood that impacted your developmental?

_____
_____
_____

2. **Relevant Family History:**

A. Are you the oldest, middle, or youngest child? _____

B. What was it like growing up?

_____
_____
_____

C. Please describe your relationship with your family of origin:

_____
_____
_____

D. Is there any information about your family's culture, ethnicity, language, or religion that is important for us to know?

_____
_____
_____

E. What is your current marital status?

Single_____ Married _____ Divorce_____ Separated _____ Widowed _____

F. How would you describe the relationship between you and your significant other?

_____
_____
_____

G. How many children do you have? _____ Ages _____

H. How would you describe the relationship between you and the children?

_____

I. _____

_____

J. How would you describe your current family circumstances?

_____

_____

_____

K. Would you consider your present network?

_____Supportive _____ Maladaptive _____ Isolated _____Other

If other, Please provide a brief explanation

_____

_____

_____

L. List Informal supports:

_____

_____

M. Describe your current housing and list the individuals residing in the household:_____

_____

_____

N. Is there any current or past exposure to crime violence? Yes _____ No _____

If yes describe.

_____

_____

_____

O. Is there any current or past experience with drugs or alcohol abuse? Yes ____ No _____

P. Do you smoke? Yes _____ No _____

Q. Any family history or sexual abuse or neglect? YES _____ NO _____

R. If Yes to any of the above please explain:

_____

_____

_____

S. Have you experienced any significant loss?

_____

_____

_____

## 3. Nutrition

A. How would you describe your appetite? Average _____ Poor _____ Excessive _____

B. Any Recent weight loss? Yes _____ No _____

C. How many meals and snacks do you eat each day? _____

D. On average, how many servings of vegetables do you eat each day? _____

E. On average how many pieces of fruit or glasses of juice do you eat or drink each day?

Fresh Fruits _____ Juice (8oz Cup) _____

F. What type of Beverages do you usually drink?

| Water | Milk | Alcohol |
|---|---|---|
| Juice _____ | Whole Milk _____ | Beer _____ |
| Soda _____ | 2% _____ | Wine _____ |
| Diet Soda _____ | 1% _____ | Hard Liquor _____ |
| Sports Drink _____ | | |

G. What is your proximity to the food market? _____

H. How do you access to market/Self _____ With Assistance _____ By others _____

I. Nutrition Concerns:

_____

_____

_____

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## 4. Social History

Check the box that applies.

| Assessing your level of social support | True | False |
|---|---|---|
| A. If you need an emergency loan $100, is there someone I could ask for it | | |
| B. There is someone who takes pride in my accomplishment and/or praises me | | |
| C. Many people I know have a positive impression off me | | |
| D. If I need an early morning ride to a medical appointment, there is no one I could ask | | |
| E. I fell there's is no one with whom I can share my most private worries and fears. | | |
| F. I would have a hard time finding someone to go with me on a fun day trip. | | |
| G. I often meet up with or talk by phone with friends and family | | |
| Score | | |

Scale: if you score 4or higher on the positives, you should have enough support in many situations. If you score three or lower, you may need to build up your social support.

## 5. Education

A. How many years of schooling did you complete? _____

B. What is the name of the last school completed?

_____

C. Are you presently employed (if applicable): Yes _____ No _____

D. Do you have any experience or interest in volunteering?

_____

E. Did you serve in the Military or Navy? Yes _____ No _____
If yes, honorable discharge? Yes _____ NO _____
Service-connected Disability Yes _____ NO _____

F. What is your primary source of income?
Social Security _____ Pension _____ SSI _____ Other _____

G. Are you able to adequately provide for yourself with this income? Yes _____ No _____

H. Do you get financial assistance for any of your daily needs? Yes _____ No _____
If yes, please explain

_____

_____

_____

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6. Mental Status (please check where appropriate)

| | | |
|---|---|---|
| 1. Appearance | ☐ Casual dress, normal grooming, and hygiene<br>☐ Other (describe) | |
| 2. Attitude | ☐ Calm and cooperative<br>☐ Other (describe) | |
| 3. Behavior | ☐ No unusual movements or psychomotor changes<br>☐ Other (describe) | |
| 4. Speech | ☐ Normal rate/tone/volume without pressure<br>☐ Other (describe) | |
| 5. Affect | ☐ Reactive and mood congruent<br>☐ Labile<br>☐ Tearful<br>☐ Blunted<br>☐ Other (describe) | ☐ normal range<br>☐ depressed<br>☐ constricted<br>☐ flat. |
| 6. Mood | ☐ euthymic<br>☐ irritable<br>☐ Elevated<br>☐ other (describe) | ☐ anxious<br>☐ depressed |
| 7. Thought Process | ☐ goal- directed and logical<br>☐ other (describe) | ☐ disorganized |
| 8. Thought Content | Suicidal ideations<br>☐ none ☐ passive ☐ active<br>If active Yes No<br>Plan ☐ ☐<br>Intent ☐ ☐<br>Means ☐ | Homicidal Ideations<br>☐ none ☐ passive ☐ active<br>If active Yes No<br>Plan ☐ ☐<br>Intent ☐ ☐<br>Means ☐ ☐ |
| 9. Perception | ☐ No hallucinations or delusions during interview<br>☐ other (describe) | |
| 10. Orientation | Oriented<br>☐ time ☐ place ☐ person ☐ self<br>☐ other (describe) | |
| 11. Memory/Concentration | ☐ short term intact<br>☐ other (describe) | ☐ long term intact<br>☐ distractible/inattentive |
| 12. Orientation | ☐ Good ☐ Fair ☐ Poor | |

Do you own any weapons (I.e., - guns, hunting knives, etc.) Yes _____ No _____
If yes Please list:

_____

_____

Are you licenses for these? Yes _____ No _____
Please list license # _____

## 7. Matching

What sort of family do you visualize living with?

_____

_____

Daily routine: (describe your usual daily schedule from waking to sleep)

_____

_____

_____

Host: (gender, age, personality, family, lifestyle, etc.)

_____

_____

_____

Caregiver preferred: Male _____ Female _____ Couple _____

Smoking ok _____ Nonsmoking _____ drinking alcohol ok _____ Non drinking _____

Religion _____ Ethnic preference _____

Children Yes _____ No _____

Geographical Area Preferred: _____

Type of dwelling: Apartment _____ Private Home _____

Stairs inside _____ stairs outside _____

First floor bedroom _____ second floor bedroom _____

First floor bathroom _____ Second floor bathroom _____

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## 8. Cultural Needs

We are interested in honoring your values and benefits. Are there any that you **would Like for us to** know about you to help to regain / maintain your health?

_____

_____

What ethic cultural group do you identify with? _____

How long have you lived in this country? _____

Do you speak, read, write, and /or understand English and /or another language?

_____

_____

And their resources /equipment or people that you normally use to assist you with communicating?

_____

_____

Are there any considerations that we should know about related to your religious beliefs/ practices, diet, prayer/meditation times, etc.?

_____

_____

Is there any treatment that are forbidden or discourage by your religious or spiritual beliefs?

_____

_____

Any Family traditions related to decision making illness, deaths, & dying?

_____

_____

Any other issues or concerns regarding your care that you would like to share:

_____

_____

_____

## 9. Recommendation

Meets Criteria for ☐ Level 1 AFC ☐ Level 2 AFC

## 10. Signatures:

I attest this assessment was completed in person on the date listed below.

AFC staff signature _____ Date _____

Signature of potential Member _____ Date _____