Universal
Psychosocial Assessment

Client #: _____

Date: _____

1. IDENTIFYING DATA and CHIEF COMPLAINT

Brief Biographical Data

- age, gender, where client was born, where client lives, who they live with
- cultural identity or ethnicity, language
- Employment (full or part time) or school status (school, grade, performance)
- Any relevant information about family of origin, marital status, children

What is the Presenting Problem? or What is the current situation requiring assistance?

- What are the symptoms? What's going on that brought the client in for services?
- Describe client's version of the problem's impact on his or her life.
- Try to gather quotes, i.e. *in client's own words*
- What does the client want to accomplish? What is their Chief Goal?

2. RECENT HISTORY OF THE PRESENTING ILLNESS and CHANGES IN FUNCTIONING

History of the Symptoms

- Age of onset of symptoms, brief description of attempts or responses to treatment
- How has client tried to cope or decrease symptoms, have symptoms ever subsided?
- What stressors are currently affecting the individual, exacerbating symptoms?
- If Updating: What are current or recent changes in Mental Health or Substance Use Disorder Symptoms? (give details and/or examples)
- **Very Important!** How are the symptoms presenting themselves right now?:
    - **frequency** (how many times per day/week?)
    - **intensity or severity** (how bad does it get?)
    - **duration** (how long does it last?)
    - **triggers** (does anything bring up the symptoms or make them worse?)

Changes in Functioning

- Describe problem: how have these symptoms impaired the client's functioning?
- or: How has the client's functioning changed? How have symptoms impacted client's level of functioning?
- examples of area of functioning: social, environmental, occupational, ability to maintain placement, academics, activities of daily living, symptom management, etc. *e.g. because client experiences [x, y, and z] symptoms, client [describe impairment]*
- **SUPER IMPORTANT:** What is baseline behavior, i.e. how was client functioning prior to onset of symptoms? e.g. What could they do that they can no longer do or do as well?
- If updating: what are current or recent changes in functional impairment(s)?
- If updating: how has client responded to treatment?

3. MENTAL HEALTH HISTORY (WHICH INCLUDES PREVIOUS TREATMENT)

Pertinent Mental Health History:

- History of Symptoms and Functional Impariment(s)
- At what age was client first involved with mental health services?
- Previous Treatment Information: start/end dates, venue, outcome, response, helpfulness. (If client is amenable, obtain **Authorization to Exchange Confidential Information** for previous mental health providers)
  e.g. "At [HOW MANY] years old, client received treatment at [WHERE] via [PROVIDER] for [WHAT]. Client was referred to services by [WHOM]? Client was in treatment from: [START DATE] to [END DATE]. As a result of treatment, [WHAT HAPPENED]. Client indicates [SUMMARIZE CLIENT'S RESPONSE TO TREATMENT]."
- Client's thoughts on previous or current treatment
- Inpatient admissions, Crisis Team evaluations.
- Reference information gathered from other sources of clinical data. Includes: mental health records, relevant family information (includes collateral contact), lab tests, and consultation reports

FAMILY MENTAL HEALTH HISTORY

- History of similar or different mental health issues/diagnosis/-es
- Family's attitude towards mental health or treatment.
- Note any stigma related to culture or family

TRAUMA OR SIGNIFICANT LOSS

- Describe trauma that client has experienced. Indicate dates, event, aftermath, treatment (if applicable). Indicate type of trauma (e.g. sexual, physical, emotional, verbal, and/or psychological). If client is victim, who and where is alleged perpetrator. CPS or APS report?
- **Any relevant CPS, APS, violence or risk issues should be further discussed in Section 8: Safety Assessment**
- Has client experienced any significant losses (e.g. break-up of relationship, divorce, sudden departure, unresolved losses)? To what extent are losses affecting client's mental health? **Risks associated with these sudden or significant losses should be further discussed in Section 8: Safety Assessment**

4. SUBSTANCE USE HISTORY

HISTORY OF SYMPTOMS AND FUNCTIONAL IMPAIRMENT

- Age of first use
- How are symptoms impacted by client's substance use
- Client's level of insight about use affecting their symptoms
- Previous Attempts at Treatment

HISTORY OF SUBSTANCE USE

Specify amount/quantity, frequency, duration, and age of first and last use (if known), and circumstance (if indicated). For this section, indicate if client is abusing or dependent. If possible, identify client's insight about their substance use on their mental health and where s/he is in the Stage of Change for reducing or eliminating substance use.

☐ tobacco: *packs per* ☐ alcohol: *drinks per*

☐ caffeine: *If more than regular use* ☐ meth: *measurement per*

☐ illicit drugs (specify type):

☐ marijuana (includes medicinal use):

☐ over-the-counter drugs (other than intended use)

☐ prescribed medication (used other than prescribed)

☐ other substances (specify, e.g. paint thinner)

"Client indicates use of SUBSTANCE @ FREQUENCY, ingesting QUANTITY via METHOD. Client began using SUBSTANCE at AGE. Client reports last usage of SUBSTANCE at WHEN. {If applicable:] Client indicates current usage and LEVEL OF MOTIVATION TO STOP. Client indicates LEVEL OF insight of effect of substance use on mental health, as evidenced by WHAT."

5. MEDICAL HISTORY and CURRENT MEDICATIONS

Describe any significant medical history that client has experienced

- Primary Care Physician: which clinic, last check-up, last bloodwork, ability to access
- Surgery/-ies, non-mental health-related hospitalizations
- Medical Conditions and treatment status
- Labs Results
- If client is amenable, obtain **Authorization to Exchange Confidential Information** for previous mental health providers

Allergies: indicate any allergies and/or adverse reactions and indicate allergen. If not present, indicate that client experiences a lack of allergies or sensitivities.

Appetite: meals per day, type of food, nutrition level; note disruption or changes in eating behavior, e.g. too little, too much, not at all. Note history of eating disorder, if relevant.

Sleep: hours per night, difficulty of onset, early awakening, and/or intermittent wakening. (If applicable, how are medical conditions exacerbating symptoms)

Exercise: level of exercise, type of exercise, impediments to exercise (if relevant)

Perinatal information: If female client with children, any information about pregnancy. If child, any relevant information about pregnancy, including complications, delivery, etc. For children and adolescents, history MUST INCLUDE prenatal and perinatal events, and relevant/significant developmental history. You may include information from other sources of clinical data, such as relevant family information and consultation records.

Substance Exposure in Utero: If indicated, summarize substance abuse history; via template below. Note if substance exposure is not indicated or not known.

e.g. "Client reports in utero exposure to SUBSTANCE @ X months of gestation"

Past Medication(s):
"DRUG @ DOSAGE via PHYSICIAN (or TREATMENT PROVIDER) for WHAT (condition). Started: DATE, Terminated/Refill: DATE. Client reports COMPLIANCE LEVEL. Describe any clinically significant or relevant information."

Current Medication(s): For this section, you can get a medication printout from the PSR
"DRUG @ DOSAGE via PHYSICIAN (or TREATMENT PROVIDER) for WHAT (condition). Started: DATE, Terminated/Refill: DATE. Client reports COMPLIANCE LEVEL. Describe any clinically significant or relevant information."

6. SOCIAL & CULTURAL HISTORY

CULTURAL FORMULATION

- How does client identify culturally? Languages Spoken? Acculturation level? Any characteristics in conflict with culture or origin or dominant culture?
- Note cultural strengths and barriers (e.g. oppression, language, documentation status)
- How do social or cultural factors impact (or are impacted) by the behavioral health condition?

SPIRITUAL IDENTITY

- Does client have any spiritual / religious / cultural influences that affect how they view mental health, their symptoms, attitude towards treatment?
- Are they helpful or hindering to client's recovery?

FAMILY HISTORY AND ENVIRONMENTAL SUPPORTS

- If working with client's family, it is important that client has provided **Authorization to Exchange Confidential Information** for the family member(s)
- Client's current living situation and daily activities
- Provide family information (nature/quality/stability of relationships with family and those that client lives with). Note if family is supportive around client's mental health recovery or if there is any need for education.
- Describe natural and community supports. Who are the people in client's life that have helped or could help them thrive?

7. CLINICALLY RELEVANT DATA

SCHOOL FUNCTIONING / HISTORY:

- History of education: last level completed, certifications or college. Literacy issues?
- Do client's symptoms impact their academic abilities/attendance?
- Does the client have an IEP/504 Plan? Date of last modification, meeting?

EMPLOYMENT FUNCTIONING / HISTORY

- History of employment: certifications, ability to maintain employment
- Do client's symptoms affect their ability to carry out their work duties/attendance?

LEGAL HISTORY

- Describe legal history including any current issues.

"On DATE, client was ARRESTED and charged with WHAT. Client was later DESCRIBE DISPOSITION OF CASE (e.g. charges dropped, probation, conviction and sentence, etc.)"

If on Probation or Parole:

"Client is currently on probation under supervision of Probation Officer NAME. Client PROVIDED OR DID NOT PROVIDE Authorization to Exchange Confidential Information identifying WHICH probation department. Client's probation began WHEN as a result of WHAT. (indicate relevant terms of probation), Client's probation to end on DATE"

BRIEF REVIEW OF CLIENT'S STRENGTHS:

- Abilities, accomplishments, talents, interests, aspirations, resources, unique individual attributes
- Indicate protective factors, as well as environmental factors, and motivators
- How will client's strengths help in accomplishing his or her treatment goals?

8. SAFETY ASSESSMENT

Assessment for Danger to Self: Discuss client's risk of hurting self intentionally or unintentionally. Also discuss efforts to manage risk.

☐ **Current Depression is severe as evidenced by almost all of the following being true:**

- ☐ depressed mood or irritability
- ☐ anhedonia
- ☐ significant weight change or appetite disruption
- ☐ disruption in sleep
- ☐ psychomotor agitation or retardation
- ☐ fatigue or loss of energy
- ☐ feelings of worthlessness or excessive guilt
- ☐ diminished ability to concentrate
- ☐ death/suicidal ideation).
- ☐ notable decrease in school/work/occupational performance
- ☐ Non-suicidal cutting behavior

☐ **Elevated risk for suicide is present by:**

- ☐ Current plan with method, means, and time-frame
- ☐ Access to firearms or weapons
- ☐ Recent loss (death, divorce, employment, housing, etc.)
- ☐ Previous suicide attempt(s)
- ☐ Limited support system
- ☐ Hopelessness or having no reason to live
- ☐ Client is unable to see a future with him or herself in it
- ☐ Giving away possessions
- ☐ History of loved one committing suicide
- ☐ Unwillingness to contract for safety

Status of suicidal plan or ideation: _____

Last time client had thoughts/plan? _____

Steps taken to manage risk or Protective Factors: _____

_____

Assessment for Danger to Others: Discuss client's risk of hurting others intentionally or unintentionally. Also discuss efforts to manage risk.

☐ **History of assaultive behavior** (note arrests, convictions restraining orders, etc): indicate dates, event, aftermath, treatment (if applicable). Indicate type of assault (e.g. sexual, physical, emotional, verbal, and/or psychological, as well as presence of abuse and neglect. Were CPS or APS reports submitted? If so, outcome?

☐ **Persistent violation of the rights of others**

Status of plan or ideation to harm others: _____

Last time client had thoughts/plan? _____

Steps taken to manage risk or Protective Factors: _____

_____

Is CPS/APS Report Indicated?

☐ **Yes** ☐ **No** If yes, outcome of CPS/APS Report _____

_____

Other concerns, behaviors, or situations that poses a higher risk for client to experience harm to self or others (non-suicidal or -homicidal). Also discuss efforts to manage risk.

- ☐ History of being unable to provide for basic needs
- ☐ Any previously-mentioned behaviors
- ☐ Destruction of property
- ☐ Drug or alcohol abuse
- ☐ Reckless driving
- ☐ Careless behaviors
- ☐ Decrease in work, academic, occupational performance
- ☐ Decrease in self-care
- ☐ Unprotected / promiscuous sexual activity
- ☐ Significant body piercings or tattoos
- ☐ Cutting / self-harming behavior w/o suicidal intent
- ☐ Unknown combination or high intake of drugs

_____

_____

9. DIAGNOSTIC ASSESSMENT

DIAGNOSTIC FORMULTION as evidenced by DSM-5 Criteria.

- Integrates Assessment Data and Provides Meaningful Foundation for Treatment Planning
- "Working Diagnostic Impression" must be aligned with DSM

Diagnosis or Condition (note if Rule-Out or Differential)	Environ-mental	Medical	Mental Health	Substance Use
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

CLINICAL IMPRESSION(S)

- What is clinician's hypothesis about current clinical presentation?
- What factors are likely to have contributed to client's current mental health symptoms or status?
- **Why is the client unable to overcome existing barriers that require specialty mental health services?**
- **Must Include a Statement of Severity**

SUMMARY OF MEDICAL NECESSITY

Describe symptoms (not diagnosis) and how they affect client's clinical functioning in an important life domain. Should be supported by data that has been gathered.

☐ Work / Occupational
☐ Academic / Educational
☐ Environmental
☐ Social Relationships
☐ Daily Living Skills
☐ Ability to Maintain Placement
☐ Symptom Management

"The client's symptoms of [WHAT] and barriers of [WHAT] impair client's ability to function in [WHAT] life domain(s)." A simple statement because you described this in Section 2.

IMPORTANT: What Strengths can Client use to be Successful? _____

See Section 7

10. RECOMMENDATION FOR SERVICES

STAGE OF CHANGE

- Where is the client on the stage of change? (e.g. precontemplative, contemplative, preparation, action, maintenance, or relapse). As evidenced by what?
- Where would client place themselves on the stage of change spectrum?
- How does client perceive treatment? What is client's desired outcome from treatment? What does the client want to work on in the short- and long-term?
- Where is the client's motivation? Is there anything that will help client meet his or her treatment goals?

RECOMMENDATIONS FOR TREATMENT

Describe practitioner's recommendations for treatment.

- What **treatment modalities** (individual, group, etc) might be helpful to this person? Why? What **interventions** are indicated (including evidenced-based)? What might be limitation to these options (e.g. are there any cultural issues)?
- What **resources** are needed? What treatments or further assessments, tests, etc. or other procedures (e.g. laboratory tests) would benefit client and client's treatment?
- How will recommended treatment address severity of symptoms described?

Note that the practitioner's recommendations may be different than what the client chooses to work on. This is where the practitioner documents their perspective or assessment of the client's needs.

DISCHARGE PLAN

- How do we know that the client is ready for discharge?
- What will it look like?

Client will be discharged from mental health services WHEN AND UNDER WHAT CIRCUMSTANCES.

PROVISIONAL TREATMENT PLAN

My Life Goal: Get client quote about what they want to do in treatment.

Problem Statement: Quote. Biographical information. What are symptoms, their frequency, and how do they impact client's functioning? What strengths can client use to help them meet the goals of the plan?

Goal #1: Get client quote about this goal. "[Client Quote]. Client will [increase, decrease, maintain] …"

Client will accomplish: To accomplish this goal, what will client do? What are the things that are observable that client will be able to show that they accomplished the goal?

Clinician will help: What are the interventions or things that the clinician will do to help client accomplish the goal?

Goal #2:

Client will accomplish:

Clinician will help:

Goal #3:

Client will accomplish:

Clinician will help: