HOPE CLINIC
a community health center

Psychosocial Assessment – Behavioral Department

This information will be treated as CONFIDENCIAL according to HIPPA regulations
After you complete this form, please fold and put it in attached envelope to ensure confidentiality. You will be called to set up an appointment for Behavioral Health services within 3 days after receipt.

Must be completed before getting an appointment for Psychiatry or Counseling

Name of Patient: _____
Name of Parent/Guardian completing this form_____
Gender: _____ **Date of Birth:** _____/_____/_____**Age**_____

Marital Status _____**Ethnicity:** _____ **Phone #**_____

Languages Spoken: _____**Need Translator? Yes___ No___**

Describe presenting problem and what do you expect to achieve in treatment:

_____
_____
_____
_____
_____
_____

Past Psychiatric/Psychological History: Have you been in treatment before? when? With whom?_____
_____

Currently taking any psychotropic Medications? (ie. Antidepressants, etc.) if yes, please list them:

_____
_____

High Risk Behaviors

None ___ Cutting ___ Anorexia/Bulimia ___Head Banging ___ Self injurious behaviors_____

Other: _____

Do you feel you have ever been exposed to trauma or traumatic event/Abuse as a victim or as a perpetrator?
YES___NO__ : Domestic Violence___ Physical__ Emotional___ Sexual___War_____
As a child___ As an adult___

Are you currently at risk of the above? Yes___ No____

Family/Social History

Where were you born/raised?:

_____
_____

Siblings: # of brothers ___ # of sisters_____

Who primarily raised the patient? _____
If you have children, specify # and ages: _____
_____
Current living situation (housing, with whom?):_____
_____

Family History of Mental Illness, and or addiction (which relative and which mental illness):
_____
_____
Employment
What is the current employment status? Employed_____ Unemployed_____ Retired_____ in the Military_____ Disable_____
Education
Highest grade completed_____: College Grad____College Undergrad_____High School_____Elementary_____
If in school, name it : _____

Religious/Spiritual background: Yes___ No____ _____

Issues Affecting Patient:
Finances ___ School___ Family relationships___ Social relationships _____Safety ___ Legal_____
Cognitive functioning ___ Physical health____Housing ___ Impulse control ___ Immigration_____
Other:_____

Developmental History : (For Minors only)
Milestones: What age did patient seat___,crawled___, walked____, talked____ how was emotional behavior___

Risk of Harm:
History of suicidal attempts: No_____ Yes_____ When?_____
Thoughts of harm yourself?
Never____
Yes right now___,
Yes__ last 30 days___
Yes __last year____
Historical/over a year_____

Have you had thoughts of harm others?
Never____
Yes right now___,
Yes__ last 30 days___
Yes __last year____
Historical/over a year_____
Have you ever been hospitalized for a psychiatric condition? No___, Yes____ Date_____Where?_____

Currently using Alcohol, Drugs: Yes___ No___, If yes describe what and frequency_____

Patient Signature or Parent/Guardian_____ Date_____