Lab Day

Assessments

gathering information and formulating it into a coherent picture of the client and his or her circumstances

SOWK 486: Theories of Practice I
Heritage University Fall 2020
Jacob Campbell, LICSW

Agenda

- Social histories
- Teach Back Activity
- Genograms & Eco-maps

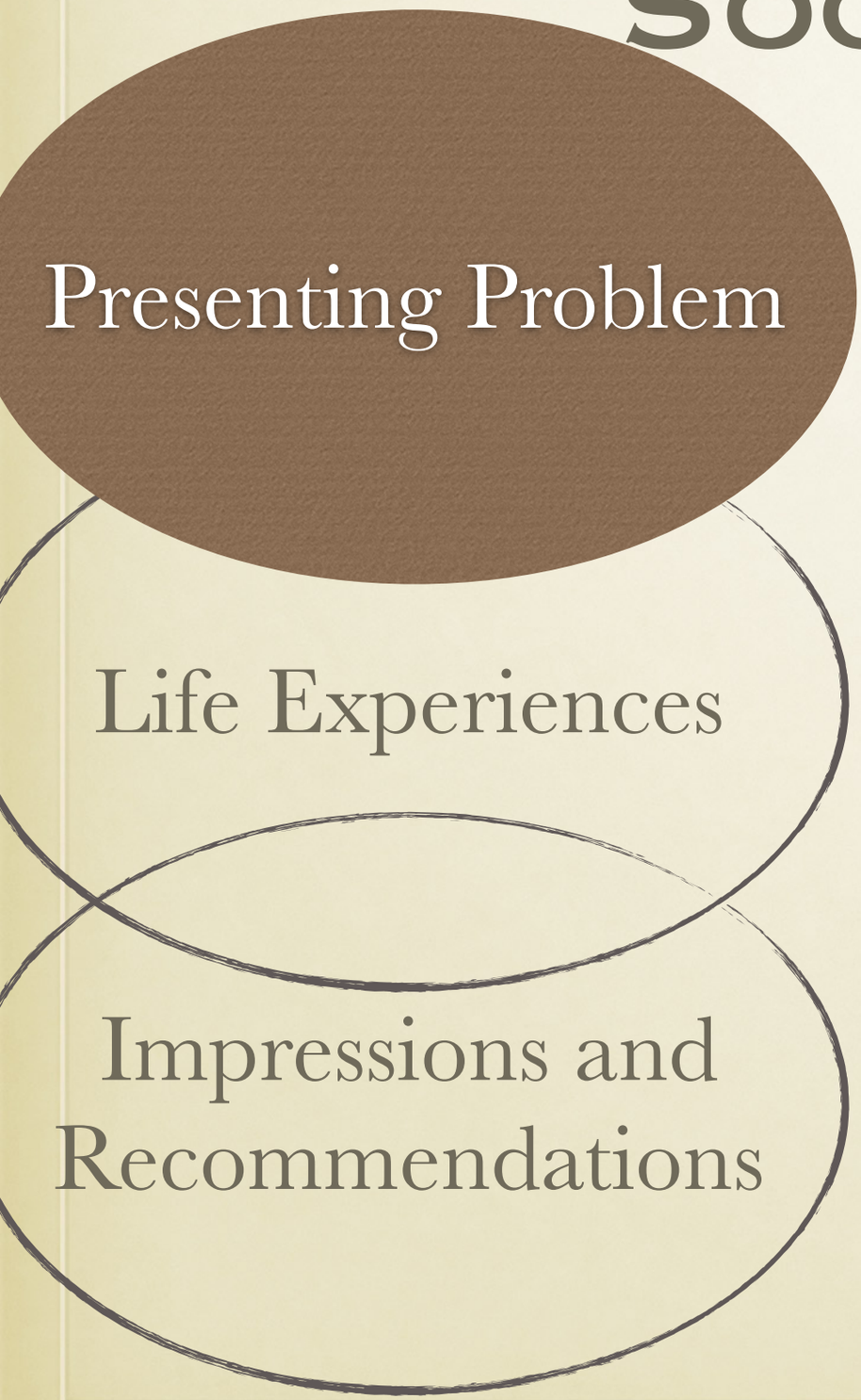
Layout of the Social History

Presenting Problem

Life Experiences

Impressions and Recommendations

Layout of the Social History



- Description and history of the presenting problem
- Introductory section

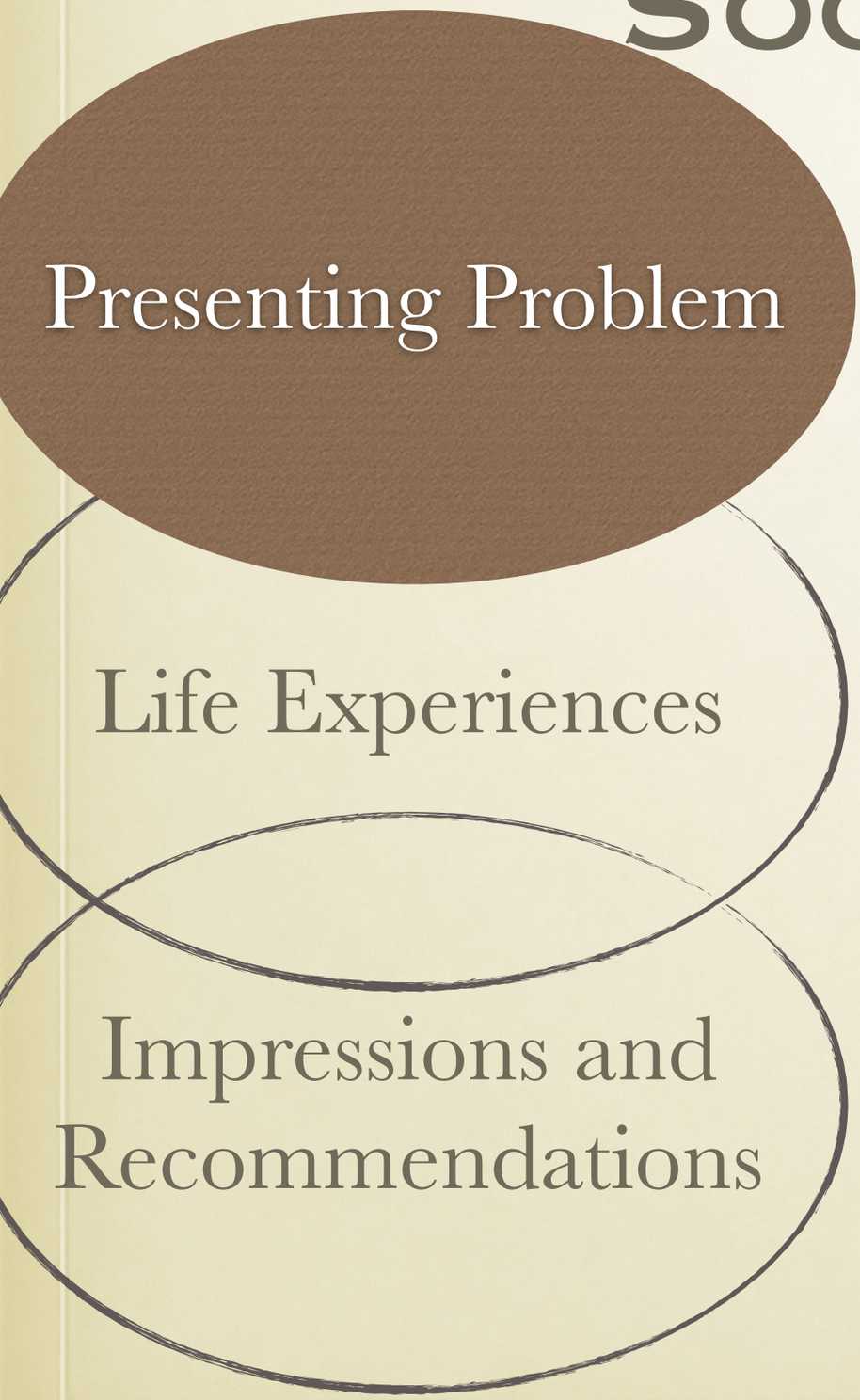
Layout of the Social History

Presenting Problem

- Description and history of the presenting problem
- Introductory section

Esmeralda, a 32 year old Hispanic married with three children female completed this mental health evaluation at the TCCH BHS Pasco office. She was accompanied by her husband and one child. Her primary language is Spanish, and the evaluation was completed in her native language. Her insurance, Medicaid, has been verified. She was referred by Crisis Response Unit after being hospitalized at Lourdes Medical Center after an attempted suicide. She presented with symptoms related to depression and anxiety.

Layout of the Social History



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Layout of the Social History

Presenting Problem

Life Experiences

Impressions and Recommendations

- Family of origin
- Birth and childhood
- Marriages and significant relationships
- Current living arrangements
- Education
- Military service

Layout of the Social History

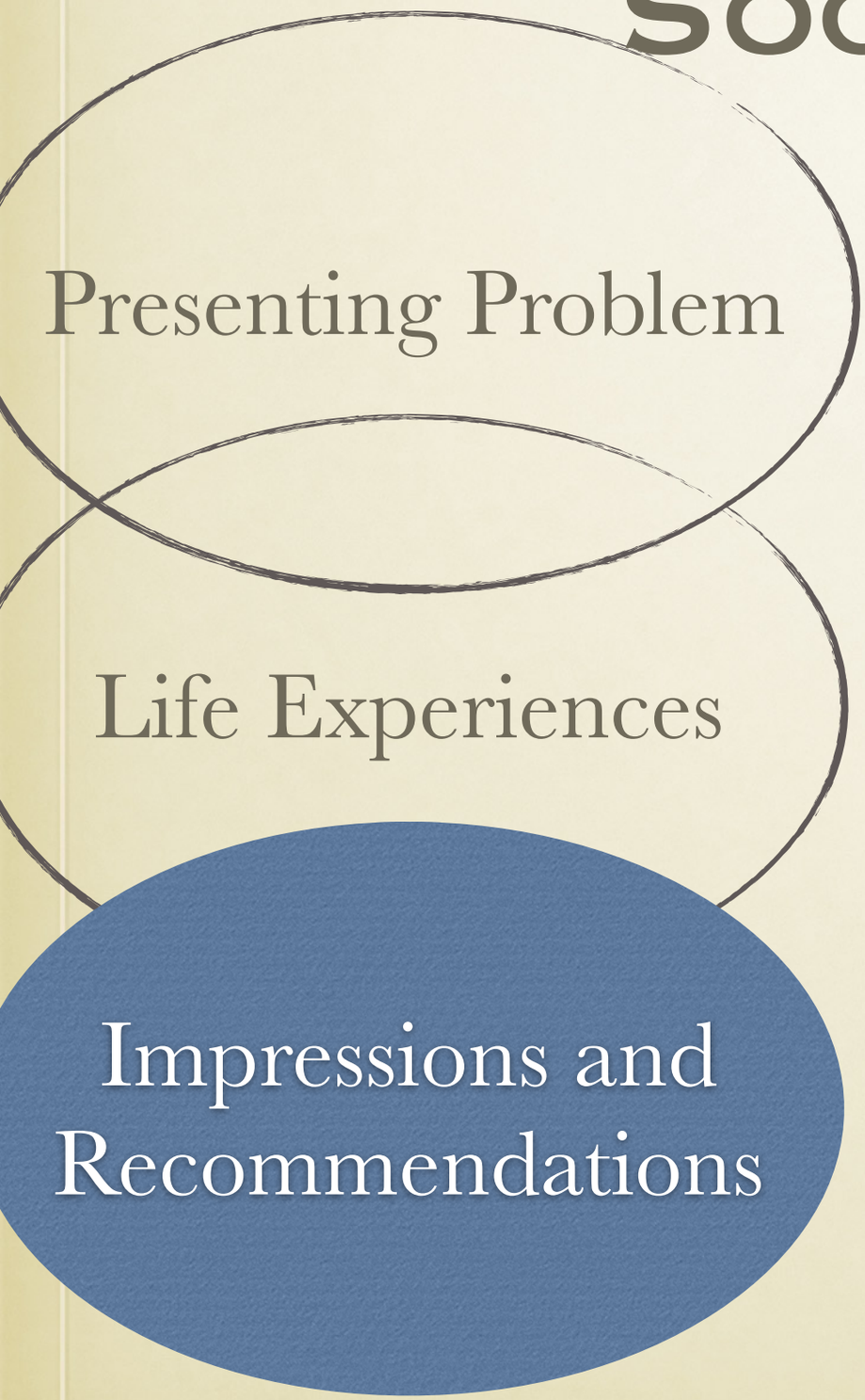
Presenting Problem

Life Experiences

Impressions and Recommendations

- Employment history
- Medical history
- Legal history
- Social and recreational interests
- Religious activities
- Client successes, strengths, and resources

Layout of the Social History



- Impressions
- Recommendations

Tri-Cities Community Health Behavioral Health Services

MENTAL HEALTH EVALUATION

Prepared by/Cred.: **Date of Intake:** **Request Of Service:**

Dimension I. Client Personal Information		
Client Name:	**Date of Birth:**	**Age:**
Gender:	**Client Ethnicity:**	
Client Place of Birth:	**Primary Language:**	**Secondary:**
Is a power of attorney needed? Yes ☐ No ☐ (If needed, explain.)		
Are legal guardianship documents needed? Yes ☐ No ☐ (If needed, explain.)		
Is there CPS involvement? Yes ☐ No ☐ (If yes, explain.)		

Dimension II. Referral & Admitting Problem
Referral Source:
Client Presenting Problem: (symptoms/length)

Dimension III: Client Treatment History, Mental Health/Psychiatric/Substance Abuse			
Name of Provider (Include dates.)	**Reason for Treatment** (e.g. CD, psych. hospital, residential, OP. Include diagnosis.)	**Medication(s) Prescribed**	**Outcome** (Successful/Unsuccessful/ AMA)

Current Substance Use:
GAIN-SS Score: ☐ **N/A**
Family/Significant Other History of Substance Use:
Is there a need for present referral to CD specialist? Yes ☐ No ☐

Dimension IV: Family/Significant Other Mental Health/Psychiatric History				
Relationship to Client	**Mental Health/ Psych History**	**Diagnosis**	**History of Suicide** (If yes, explain.)	**History of Homicide** (If yes, explain.)
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**

Dimension V: Abuse/Neglect
Client History of Abuse/Neglect: (If abuse is reported by a client age 17 or younger, a documented CPS referral must occur within 48 hours. Call 509-737-2800.)
Dimension VI: Crisis/Risk Assessment
Client History of Suicide/Homicide: (Ideation, plan, means, attempts when/age?)
Current Crisis/Risk Assessment: (Must include current risk of suicide/homicide/risk of self-harm.)
Does a referral for provision of emergency/crisis services need to be made at this time? Yes ☐ No ☐ (If yes, identify referral provider.)
Present Treatment Need Grief/Loss Issues:
Dimension VII: Client Medical History
Has the client ever suffered from a head injury? Yes ☐ No ☐ Age: Result:
Is the client currently or recently pregnant? Yes ☐ No ☐ (If yes, how many months?) **Has the client recently given birth? Yes ☐ No ☐** (If yes, how long ago?)
Is there a Medical Advance Directive in place? Yes ☐ No ☐ (If yes, does ct wish to provide a copy?)
Medical History: (Include any/all hospitalizations and reasons.)
Client History/Presence of Chronic Infections/Diseases: (Incl. HIV, Hepatitis, treatments.) ☐ **Yes** ☐ **No** (If yes, explain.)
Client Present Healthcare Needs:
Has the primary care provider been notified? Yes ☐ No ☐ **Primary Care Provider Name:** (If no primary care provider was identified, name the provider that you are referring the client to.)
Is an EPSDT referral needed? (for anyone under age 21) ☐ **Yes** ☐ **No** **If needed, has an EPSDT letter been sent to the medical provider? ☐ Yes ☐ No ☐ N/A**
Current Medications: (Include dosage and the reason prescribed.)
Dimension VIII: Psychosocial
Family Support System:
Peer Support System:
Provider Support:
Employment/Education History:
Cultural Issues/Religious Beliefs Identified: ☐ Yes ☐ No (If yes, explain.) **Has a consult referral been made? ☐ Yes ☐ No** (If yes, what kind?)
Sexual Orientation Need(s): ☐ Yes ☐ No (If yes, explain.)
Functional Strengths/Interest of Client and/or Family:
Dimension IX: Legal Issues
Present/Past Legal Issues: (charges and dates)
Court ordered to treatment? ☐ Yes ☐ No **LRA Client? ☐ Yes ☐ No**
DOC supervision? ☐ Yes ☐ No (If so, document evidence of oral or written notification.) **Adult Parole: ☐ Yes ☐ No** (If so, document evidence of oral or written notification.) **Adult Probation: ☐ Yes ☐ No** (If so, document evidence of oral or written notification.) Name of PO: Phone Number: County:

Juvenile Court: ☐ **Yes** ☐ **No** (If so, document evidence of oral or written notification.)
Name of JPO: Phone Number: County:

Dimension X: Developmental

History of Developmental Delays/Need: (Specify.)

Present Services in Place: (i.e. 504, IEP, SSI, DDD, DVR)

Dimension XI: Environmental Need/Barriers to Treatment

Does the client have problems with any of the following? (Please check all that apply.)
☐ Housing ☐ Food ☐ Clothing ☐ Economic ☐ Employment ☐ Transportation ☐ Education
☐ Legal ☐ Social/Recreational ☐ Primary Support Network/Death or Loss ☐ ADL's
☐ Chronic Medical Condition(s)/Access to Healthcare ☐ Other Psychosocial/Environmental Problems

Current Mental Status

Appearance: . **Psychomotor Behavior:** . **Attention and Concentration:** . **Speech:** .
Thought Process: . **Orientation:** . **Memory:** . **Level of Cooperation/Relating:** .
Affect: . **Mood:** . **Thought Content:** . **Hallucinations:** . **Delusions:** .
Suicidal & Homicidal Ideation: . **Phobias:** . **Judgment:** . **Insight:** .

Admitting Diagnoses

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V: (Current GAF)

Inter-agency Services Needed

Referral to Therapy:	☐ **Yes** ☐ **No**	Referral to Case Management:	☐ **Yes** ☐ **No**
Referral to Psychiatrist:	☐ **Yes** ☐ **No**	Referral to Nueva Substance Abuse Dept.:	☐ **Yes** ☐ **No**

Clinical Summary/Recommendation for Treatment:

Have all releases of information been obtained for all formal/informal supports? (e.g. medical providers, legal providers, DSHS, etc.) ☐ **Yes** ☐ **No**

_____ _____
Intake Staff Signature/Cred. **Date**

Practice with Social Histories

- Family of origin
- Birth and childhood
- Marriages and significant relationships
- Current living arrangements
- Education
- Military service
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- Social and Recreational interests
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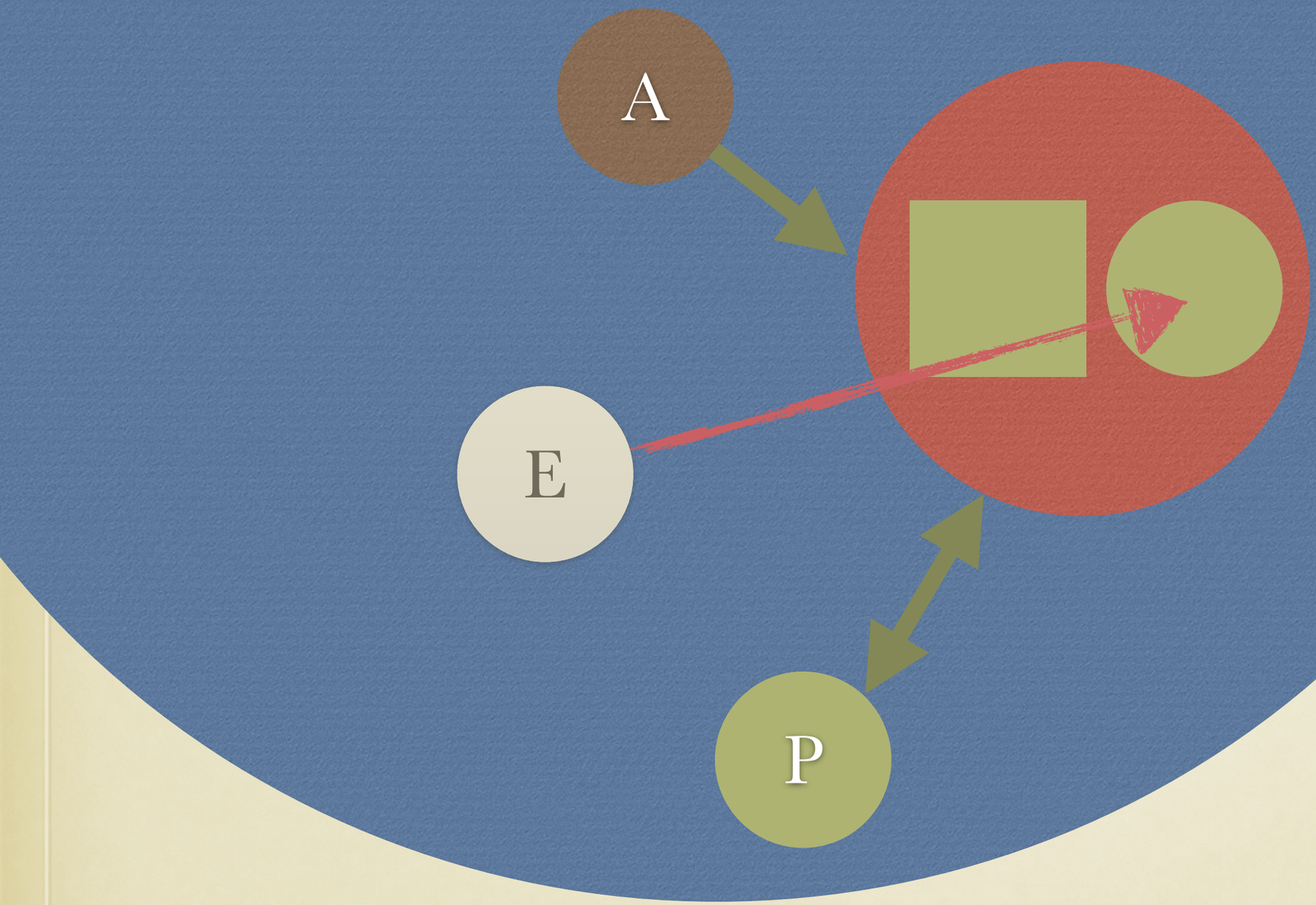
Teach Back Activity

Family Assessments



Family Assessments