



Consent & Assessments Examples

Fall 2025 SOWK 581 Week 03

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Week 03 Lecture Video

Agenda

- Assignments for the Week
- Consent form
- Simple Assessment Example
- MH Evaluations

Learning Objective

Identify the common categories for biopsychosocial assessments and what information clinicians generally gather in those sessions.

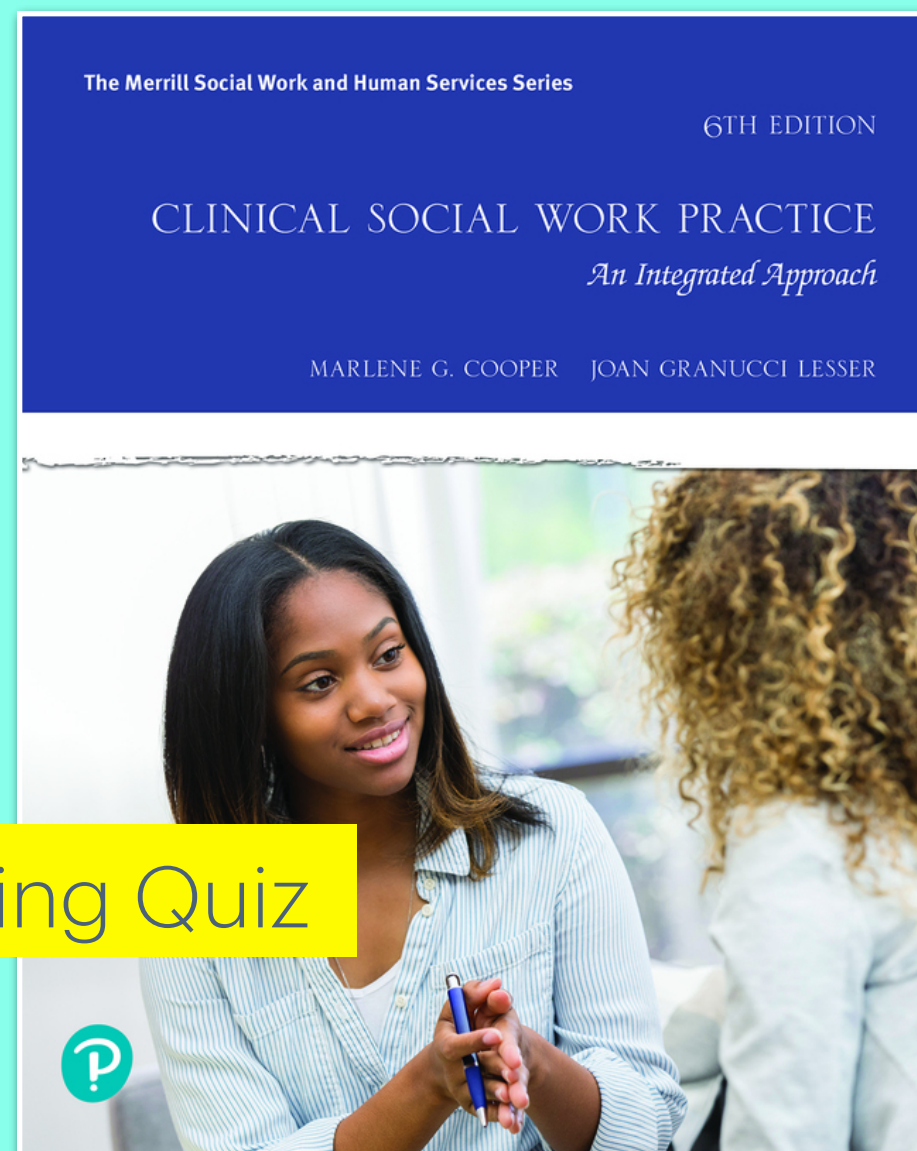
Week 03 Assignments

What you are working on this week

Write

Make at least six replies across the forums

- Chapter 03 Reflection Questions
- Developing a Consent Form for the Case Study Paper
- Questions Used and Content Evaluated in Developing a Biopsychosocial Assessment
- Developing the Form for Your Biopsychosocial Assessment
- Actor Representation of Mental Health Disorder and Mental Status Examination



Additional
Resource in
Forums

Read

Chapter 3: The
Biopsychosocial
Assessment

Renn and John
(2019) *Mental
Status Examination*



Consent Forms

What you will be doing

Risks/benefits

Confidentiality

Voluntary participation

Student Social History

Pasco School District #1

Report prepared by:
Sources of Information:

Personal Information

Student Name:	Gender:
Student ID:	School:
Date of Birth:	Ethnicity:
Age:	Place of Birth:
Primary Language:	Secondary Language:

Presenting Problem

Functional Strengths

Presenting Problem

Behavior Related Concerns at School

Behavior Related Concerns at Home

Family Basic Needs

Simple Assessment Example

Student Social History
form I created and used at
the Pasco School District



Mental Health Evaluation Example

Dimension I. Client Personal Information

Dimension II. Referral & Admitting
Problem

Dimension III: Client Treatment History,
Mental Health/Psychiatric/Substance
Abuse

Dimension IV: Family/Significant Other
Mental Health/Psychiatric History

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 <input type="checkbox"/> No <input type="checkbox"/> (If needed, explain.)				
Are legal guardianship documents needed? Yes <input type="checkbox"/> No <input type="checkbox"/> (If needed, explain.)				
Is there CPS involvement? Yes <input type="checkbox"/> No <input type="checkbox"/> (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: <input type="checkbox"/> N/A Family/Significant Other History of Substance Use: Is there a need for present referral to CD specialist? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Dimension IV: Family/Significant Other Mental Health/Psychiatric History				
Relationship to Client	Mental Health/ Psych History Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	Diagnosis	History of Suicide (If yes, explain.) Yes <input type="checkbox"/> No <input type="checkbox"/>	History of Homicide (If yes, explain.) Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>



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 <input type="checkbox"/> No <input type="checkbox"/>		
(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 <input type="checkbox"/> No <input type="checkbox"/> Age: Result:		
Is the client currently or recently pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, how many months?)		
Has the client recently given birth? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, how long ago?)		
Is there a Medical Advance Directive in place? Yes <input type="checkbox"/> No <input type="checkbox"/> (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.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
(If yes, explain.)		
Client Present Healthcare Needs:		
Has the primary care provider been notified? Yes <input type="checkbox"/> No <input type="checkbox"/>		
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) <input type="checkbox"/> Yes <input type="checkbox"/> No		
If needed, has an EPSDT letter been sent to the medical provider? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain.)		
Has a consult referral been made? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, what kind?)		
Sexual Orientation Need(s): <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
LRA Client? <input type="checkbox"/> Yes <input type="checkbox"/> No		
DOC supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No (If so, document evidence of oral or written notification.)		
Adult Parole: <input type="checkbox"/> Yes <input type="checkbox"/> No (If so, document evidence of oral or written notification.)		
Adult Probation: <input type="checkbox"/> Yes <input type="checkbox"/> No (If so, document evidence of oral or written notification.)		
Name of PO: Phone Number: County:		

Mental Health Evaluation Example

Dimension V: Abuse/Neglect

Dimension VI: Crisis/Risk Assessment

Dimension VII: Client Medical History

Dimension VIII: Psychosocial

Dimension IX: Legal Issues



Mental Health Evaluation Example

Dimension X: Developmental

Dimension XI: Environmental
Need/Barriers to Treatment

Current Mental Status

Admitting Diagnoses

Inter-agency Services Needed

Juvenile Court: <input type="checkbox"/> Yes <input type="checkbox"/> 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.)	
<input type="checkbox"/> Housing <input type="checkbox"/> Food <input type="checkbox"/> Clothing <input type="checkbox"/> Economic <input type="checkbox"/> Employment <input type="checkbox"/> Transportation <input type="checkbox"/> Education	
<input type="checkbox"/> Legal <input type="checkbox"/> Social/Recreational <input type="checkbox"/> Primary Support Network/Death or Loss <input type="checkbox"/> ADL's	
<input type="checkbox"/> Chronic Medical Condition(s)/Access to Healthcare <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral to Case Management: <input type="checkbox"/> Yes <input type="checkbox"/> No
Referral to Psychiatrist: <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral to Nueva Substance Abuse Dept.: <input type="checkbox"/> Yes <input type="checkbox"/> 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.) <input type="checkbox"/> Yes <input type="checkbox"/> No	

Intake Staff Signature/Cred. _____

Date _____

