Psychosocial Assessment

Patient's Full Name: Joshua T. Regalado **Date Assessed:** July 2, 2022

Patient's Date of Birth: January 18, 1997

Clinician's Full Name: Roberto G. Corbin

Presenting problem: What brings you patient here today?

Depression and anxiety.

I. History of Present Illness

None before this.

II. Past Psychiatry/Psychological History

None before this.

Please have them rate the following symptoms based on how they apply to them.

0 = not present, **1 =** mild, **2 =** moderate, **3 =** severe

Depression	2	Memory Problems	0
Anxiety	2	Loss of Interest	1
Mood Swings	1	Irritability	2
Appetite Changes	1	Excessive Worry	2
Sleep Changes	1	Suicidal Ideation	0
Hallucinations	0	Relationship Issues	0
Work Problems	2	Low Energy	3
Racing Thoughts	2	Panic Attacks	2
Confusion	1	Obsessive Thoughts	2
		Ritualistic Behavior	2
		Checking	2
		Counting	2
		Self-Injury	0
		Difficulty Concentrating	3
		Hyperactivity	0

Have them describe a brief history of their present symptoms.

Work has been too much for them lately. They are and look really exhausted. He said it's just work work work, he's underpaid, and he doesn't spend time for himself and with others, at least lately. He eats less. He drinks more alcohol than he should. He just sleeps so that his intrusive thoughts don't bother him. His family and friends are worried, so he says.

What effect have they had on their life?

It's impacting his self-care and relationships. For the latter, it's more of he's not spending time with others as much.

Have they ever been treated for a mental health problem? If yes, have them describe their treatment.

No, this is the first time, apparently.

Have they ever had a mental health hospitalization? If yes, have them describe their experience.

No.

III. Past Medical History

Previous surgeries/Major Illnesses/Medical Diagnoses (please include reason and year):

He's asthmatic. He says it gets triggered when he's stressed. He's been diagnosed with it since 2005 because of excessive coughing triggered by sudden shifts in temperature and weather.

Please list any additional health information that may be important for you, therapist, to know (including any medication or other allergies or problems with pain):

None.

Current Medication	Dosage	Prescribing Physician	Last Dose	Taking as Prescribed?

Are they having any difficulty with pain? If yes, have them describe.

Do they use tobacco? ☐ Yes ☐ No

If yes, how many amounts of tobacco do they use per day? _____

If yes, how many years have they been using tobacco? _____

Do they drink alcohol? ☐ Yes ☐ No

If yes, what type of alcohol do they drink? _____

How many and how often do they drink? _____

Have they ever experienced any form of withdrawal symptoms, such as hallucinations, tremors, excessive sweating, nausea, or vomiting? If yes, have them describe.

Have they ever experienced blackouts? If yes, have them describe what causes it and how often they experienced them.

Have they ever used illicit drugs or taken more medication than prescribed? If yes, what type of drugs, illicit or not, did they take? When was the last time they took one, and how often did they take them?

If they are not presently drinking or using, have they ever abused substances in the past? If yes, what did they drink or take? How often and how much did they drink or take?

Have they ever received treatment for substance abuse? If yes, what type of treatment did they get and when?

Have they ever been involved in any recovery or support programs? If yes, have them describe their experience.

Are they aware of their triggers that cause them to drink or use? If yes, what are their triggers?

Have they ever had any legal issues related to the use of alcohol or other drugs? If yes, have them describe these issues, mention the name of the offense, and the dates they were charged.

Have you ever…

- **Binged on food?** ☐ **Yes** ☐ **No**
- **Gone without eating?** ☐ **Yes** ☐ **No**
- **Vomited on purpose?** ☐ **Yes** ☐ **No**
- **Use laxatives to purge?** ☐ **Yes** ☐ **No**

IV. Allergies

Do they have any allergies? If so, please describe.

V. Suicidal/Homicidal Ideation

Do they have thoughts of self-harm or harming others?

How do they manage these thoughts?

Have they enacted these thoughts?

Any high-risk behaviors to note?

- [ ] None
- [ ] Cutting
- [ ] Anorexia/Bulimia
- [ ] Headbanging
- [ ] Self-harming behaviors
- [ ] Violent behaviors
- [ ] Others: _____

VI. Family History

Have them describe the family in which they were raised.

Have them describe their current relationship with your family of origin.

Is there any history of mental health or substance abuse problems in their family?

VII. Family History

Are they: ☐ Single ☐ In a relationship ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

How many times have they been married? _____

Dates of previous marriages, if any? _____

Do they have any concerns regarding their marriage or relationship?

Do they have any children? If so, list down how many and what their ages are.

Do they have any friends? ☐ Yes ☐ No

Do they regularly participate in social activities? ☐ Yes ☐ No

Do they have a support system? If yes, who are the people who are part of it?

VIII. Educational History

How far did they go in school? _____

Did they have any learning or behavioral issues in school? If so, have them describe these issues.

IX. Work History

Do they work? ☐ Yes ☐ No

If yes, what is the name of their employer? _____

If yes, how long have they been working for their current employer? _____

What do they feel about their job/employer?

X. Trauma and Development

In the past year, has the patient been hit, kicked, or physically hurt by another person? If yes, have them explain.

Is the patient in a relationship with someone who threatens or physically harms them? If yes, have them explain.

Has the patient been forced to have sexual contact with someone that they were not comfortable with?

Has the patient ever been abused? If so, by whom and what did they do to the patient?

What was their childhood like: ☐ Traumatic ☐ Painful ☐ Uneventful

Have them describe their childhood in relation to their personality, school, friends, and hobbies.

Have them describe any traumatic experiences they've had back in their childhood. Make sure to indicate their age when they occurred.

XI. Legal Status

- ☐ No legal problems
- ☐ Parole
- ☐ Probation
- ☐ Charges pending
- ☐ Jailed before
- ☐ Has a guardian

XII. Sexuality

What is your patient's sexual orientation?

- ☐ Heterosexual
- ☐ Homosexual
- ☐ Bisexual
- ☐ Other: _____

What is their gender?

- [ ] Male
- [ ] Female
- [ ] Non-binary

Ask the patient if they are accepted for their sexual orientation and gender identity or if they've been discriminated against for those reasons.

XIII. Spirituality

Does your patient have any spiritual beliefs? _____

Do they participate in religious gatherings or activities? If so, have them describe these gatherings or activities?

How do they feel about their beliefs, especially if they were brought up with those beliefs?

Have they been discriminated against for their beliefs? If so, have them describe their experience.

XIV. Cultural Background

What is your patient's race/nationality? Have they ever been discriminated against for their race/nationality? If so, have them describe their experience with discrimination.

XV. Financial Background

How is your patient's financial situation?

XVI. Coping Skills and Mechanisms

How does your patient cope whenever they are distressed, especially when it comes to their current problem?

XVII. Interests, Hobbies, and Skills

What hobbies does the patient have?

What is the patient good at?

What gives the patient pleasure?

XVIII. Mental Status Assessment

(Describe any deviation from normal under each category.)

Arousal/Orientation

- ☐ Alert
- ☐ Sleepy
- ☐ Attentive
- ☐ Unresponsive
- ☐ Other: _____
- ☐ Oriented to person
- ☐ Oriented to place
- ☐ Oriented to time
- ☐ Confused

Appearance

- ☐ Well groomed
- ☐ Good eye contact
- ☐ Poor eye contact
- ☐ Disheveled
- ☐ Other: _____
- ☐ Disheveled
- ☐ Bizarre
- ☐ Poor hygiene
- ☐ Inappropriate dress

Behavior/Motor Activity

- ☐ Normal
- ☐ Restless
- ☐ Agitated
- ☐ Lethargic
- ☐ Abnormal facial expressions
- ☐ Tremors
- ☐ Tics
- ☐ Other: _____

Mood/Affect

- [ ] Normal
- [ ] Anxious
- [ ] Careless
- [ ] Depressed
- [ ] Irritable
- [ ] Inability to sense emotions
- [ ] Flat
- [ ] Liable
- [ ] Euphoric
- [ ] Indifferent
- [ ] Other: _____

Speech

- [ ] Normal
- [ ] Lous
- [ ] Halting
- [ ] Nonverbal
- [ ] Pressured
- [ ] Rapid
- [ ] Slurred
- [ ] Limited
- [ ] Soft
- [ ] Incoherent
- [ ] Other: _____

Attitude

- [ ] Cooperative
- [ ] Suspicious
- [ ] Uncooperative
- [ ] Hostile
- [ ] Guarded
- [ ] Other: _____

Thought Process

- [ ] Intact
- [ ] Loose associations
- [ ] Racing
- [ ] Flight of Ideas
- [ ] Unable to think abstractly
- [ ] Word Salad
- [ ] Tangential
- [ ] Circumstantial
- [ ] Concrete thinking
- [ ] Neologisms
- [ ] Other: _____

Thought Content

- [ ] Normal
- [ ] Obsessive
- [ ] Phobia
- [ ] Preoccupations
- [ ] Hypochondriasis
- [ ] Delusions
- [ ] Other: _____

Delusions

- [ ] None
- [ ] Somatic
- [ ] Religious
- [ ] Ideas of reference
- [ ] Persecutory
- [ ] Thought broadcasting
- [ ] Grandiose
- [ ] Thought insertion
- [ ] Other: _____

Hallucinations

- [ ] None
- [ ] Religious
- [ ] Visual hallucinations
- [ ] Command hallucinations
- [ ] Other: _____

Describe: _____

_____

Impulse Control

- [ ] Normal
- [ ] None
- [ ] Partial
- [ ] Frequently participates in activities without planning or thinking about them
- [ ] Limited
- [ ] Poor

Judgment

(What would you do if there was a fire in a crowded movie theater?)

- [ ] Normal
- [ ] Poor

Cognition/Knowledge

Orientation

- [ ] Person
- [ ] Place
- [ ] Time

Attention

Can the patient spell W-O-R-L-D backwards? [ ] Yes [ ] No

Memory

Immediate recall of 3 objects ____ /3 Recall after 5 minutes ____ /3

Naming

Point out three objects. How many can the patient name? ____ /3

Visual-spatial

Can the patient copy intersecting pentagons? ☐ Yes ☐ No

Praxis

Can the patient follow a three step command? ☐ Yes ☐ No

Calculations

Serial 7's (how many times can the patient correctly subtract 7 from 100): _____

Abstractions

☐ Comprehends

☐ Does not comprehend

XIX. Insights

Is the patient able to meet their basic needs?

What are the areas of concern for this patient?

☐ None

☐ Activities of daily living

☐ Work

☐ Finances

☐ School

☐ Family relationships

☐ Social relationships

☐ Safety

☐ Legal

☐ Cognitive functioning

☐ Physical health

☐ Housing

☐ Impulse control

☐ Social skills