Kirkbride Center

A Member of the Corecare Systems, Inc.
Behavioral Healthcare Network

Psychosocial Evaluation

Patient Label

Date _____ D.O.B _____ Gender_____ Age _____

Patient Name_____ Maiden Name_____ Race _____

Address _____ City _____ State _____

Zip _____

Home Number (_____)_____ - _____

Marital Status_____ Length of Time Married_____ Times Married _____

Client has a current, valid* PA state picture ID with them in treatment (verify by sight) ☐ Yes ☐ No
**Make sure that their address coincides with their funding source, i.e. if they're CBH that the ID shows a Philadelphia Country address. If not, new ID may need to be obtained prior to discharge to ensure transfer to outpatient treatment.*

1. CHEMICAL USE HISTORY

SUBSTANCE	Denies History of Use	Age of first use	Age of heavy use	How did you get started for the first time? Peers/ family/ party, etc.	Last Six Months			When did you use last time?
					How much do you use?	How frequently?	Route IV/ Snort/ Smoke/ swallow, etc.	
Alcohol Beer Liquor Wine	☐							
Marijuana / Hash	☐							
Amphetamines / Meth Stimulants Speed	☐							
Cocaine / Crack / Powder Rock Freebase	☐							
Tranquilizers / Valium Xanax Klonopin	☐							
Barbiturates / Downers Sedatives Reds	☐							
Hallucinogens LSD Acid PCP Dust	☐							
Inhalants Glue Paint Rush	☐							
Heroin	☐							
Synthetic Opiates Methadone Morphine	☐							
Painkillers / Vicodin Percocet Demerol	☐							
Over-the-Counter Pills Nyquil Laxatives Diet	☐							
Gambling / Lottery Horses Casinos	☐							
Tobacco Cigarettes Chewing	☐							
Caffeine Coffee Pills	☐							
Other Substances / Addictions:	☐							
	☐							

☐ Blackouts ☐ Shakes / Tremors ☐ Seizures ☐ Use to stop withdrawal symptoms
☐ Social isolation ☐ Injuries / Accidents due to use ☐ Hiding use from others ☐ None

Patient Label

Factors leading to admission

How has substance abuse affected your life? (socially, physically and mentally)

With whom do you live? If homeless what was your last stable residence? Where are you staying?
With mom
Does anyone at your residence use?
no
Where will you reside after discharge? ☐ Home ☐ Transitional Living ☐ Boarding Home ☐ Shelter ☐ Recovery House

☐ Halfway House ☐ Other _____

Chemical Dependence Treatment History Including IOP/OP

Dates	Facility	Treatment Type	Outcome

Psychiatric Treatment History

Dates	Facility	Treatment Type	Outcome

What is different about this treatment?

2. PERIODS OF SOBRIETY (When, how long, what kept you sober?)

What led to relapses?

3. RISKS ALERTS

SUICIDE / SELF - INJURIOUS BEHAVIOR

a. Current suicidal / homicidal ideation: ☐ Yes ☐ No
If yes, describe:

b. Recent suicidal ideation and / or self-endangering behavior: ☐ Yes ☐ No
If yes, describe:

c. Past suicidal and / or self-endangering behavior: ☐ Yes ☐ No
If yes, describe:

ELOPEMENT / AMA

a. Patient verbalizing current desire to possibly leave treatment: ☐ Yes ☐ No
If yes, describe:

b. List elopements from prior treatment (date / facility):

SEXUAL HISTORY

a. Does the patient report a history of sexual aggression? ☐ Yes ☐ No
If yes, explain:

b. Have you ever exchanged sex for favors? ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
If yes, explain:

c. Have you engaged in sexual behavior in order to support your addiction? ☐ Yes ☐ No
If yes, explain:

d. Are you a survivor of sexual abuse? ☐ Yes ☐ No
If yes, explain:

e. Sexual Orientation: ☐ Sexually Active ☐ STI Hx ☐ Multiple Partners ☐ Safe Sex

4. FAMILY MEDICAL & SOCIAL HISTORY * ✓ Yes response

	Living*	Biological*	Age	Cause of Death	Describe Current Relationship	Cancer*	Heart Disease*	Diabetes*	Addiction*	Psychiatric*	Other (Explain)
Father	☐	☐	[redacted]		[redacted]	☐	☐	☐	☐	☐	If parents are living, what are their names and their phone numbers?
Mother	☐	✔	[redacted]		[redacted]	☐	☐	☐	☐	☐	
Siblings	☐	☐				☐	☐	☐	☐	☐	
	☐	☐			[redacted]	☐	☐	☐	☐	☐	
	☐	☐				☐	☐	☐	☐	☐	
Do you have children? If yes, How many? What are their names?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐			NONE	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	If children are below 18 years of age, who do they live with? Their relationship with the children. (aunt, uncle, grandmother, etc.)
Significant Others	☐	☐				☐	☐	☐	☐	☐	

Developmental History and Problems

Describe the type of environment your neighborhood provided:

[redacted]

Describe the overall climate of your childhood home? (Grew up with both parents, single parent, if parents are separated, how old was the patient when the parents separated?

[redacted]

Did your family move often? ☑ Yes ☐ No If yes, why?

[redacted]

Any other trauma during childhood?

Have you been abused?	Yes	No	Explain
Physical	☐	☐	[redacted]
Emotional	☐	☐	
Sexual	☐	☐	
Incest	☐	☐	

Childhood Behaviors:

☐ Bedwetting ☐ Nightmares ☐ Fears/Phobias ☐ Running Away
☐ Fighting ☐ Stealing ☐ Depression ☐ Skipping School
☐ Anxiety ☐ Insecurity ☐ Suicidal Thoughts ☐ Difficulty Making Friends
☐ None

Psychological or Psychiatric treatment during childhood years?

Do you have a history of exploitation (financial/ emotional/ sexual)?
Yes / No If yes, please explain

5. RESOURCE HISTORY

EDUCATION

A. Highest grade level completed_____ B. If not completed, explain circumstances _____

List any problems (cutting, failing, suspensions, etc) _____

C. Certificate obtained? (Diploma, GED, Degree, License, etc.)_____

D. Explain effects of addiction on your schooling _____

_____

E. Education plans for the future? _____

Which methods help you to learn (check all that apply):

☐ Watching ☐ Listening ☐ Reading ☐ Writing ☒ Hands-on/by doing ☐ With others ☐ By myself ☐ All of the Above

Adolescents - A. Learning problems? _____

B. Extracurricular activities? _____

Literacy - Can patient read and write? _____

MILITARY

A. Were you ever in the service? ☐ Yes ☐ No Branch_____ Date you enlisted:_____ Date you entered: _____

B. Combat experience?_____ C. Type of discharge?_____ Date of discharge: _____

D. Eligible for VA Benefits? _____

EMPLOYMENT / VOCATIONAL

A. Currently employed? ☐ Yes ☐ No Where employed / Title _____

How long there?_____ Drug / Alcohol use at work? ☐ before ☐ during ☐ after _____

Explain effects of addiction on current job _____

_____

B. Chart previous employment:

Type of Work	Dates	Reason for leaving (Include D/A problems)

C. Explain effects of addiction on previous employment _____

_____

D. Is there a vocational or training program in which you are interested in pursuing? _____

_____

E. What is your dream job? _____

FINANCIAL

A. How has your addiction affected you financially? _____

_____

B. Behind on bills? (Mortgage, utilities, loans, rent) ☐ Yes ☐ No How much debt? _____

C. What is your current means of financial support? _____

D. How much did you spend on your drug / alcohol use? _____

E. How did you afford the drugs / alcohol you are using? _____

_____

LEGAL HISTORY

A. Chart legal history (Include DUI's, arrests, convictions, restraining orders, probation / parole)

Offense	Age	Consequences (Jail/ Probation/ fine, etc.)	Open / Closed	If Open Next Court Date

Were you referred to treatment by FIR, or are you court stipulated? ☐ Yes ☐ No

B. Any current parole or probation? _____

Probation / Parole Officer's name & telephone number's _____

C. Is DHS / CYS / or Custody / Family Court involved? ☐ Yes ☐ No If yes, explain: _____

D. Describe any illegal behaviors and activities in which you have participated (selling drugs, sex work, etc.) _____

_____

ASSESSMENT OF SPIRITUAL ORIENTATION

1. Did any religious group, church or institution have an influence on you as a child? If yes, explain:

2. Does any religious group, church, or institution influence you now?

3. Do you believe in a “Higher Power”? If yes, please explain, what kind of higher power?

4. Would you like a “Higher Power” to play a role in helping you meet your needs and desires? If so, how?

5. Is it a sign of weakness to trust and depend on others to do things for you? Why or why not?

6. What are the cultural factors that you think can affect your treatment?

LIFESTYLE / LEISURE

A. Are you currently in a relationship? Name: _____

B. Do you have any sober support (family/friends/sponsor)? ☐ No ☐ Yes If yes, list: _____

_____

_____

C. Do you have an ICM / Case Manager? ☐ Yes ☐ No If yes, Name _____ Agency _____ PH. _____

D. Leisure activities you enjoy without drugs or alcohol / coping skills _____

MENTAL STATUS / EVALUATION OBSERVATIONS

Mood / Affect ☐ congruent ☐ depressed ☐ broad ☐ euphoric ☐ flat ☐ angry ☐ tearful ☐ labile ☐ other _____
Eye Contact ☐ good ☐ lacking ☐ diminished ☐ fleeting
Speech ☐ normal ☐ pressured ☐ abnormal _____
Facial Expression ☐ normal ☐ calm ☐ hostile ☐ vacant ☐ alert ☐ pained
Judgment ☐ good ☐ fair ☐ poor
Thought process ☐ organized ☐ coherent ☐ tangential ☐ flight of ideas
Motivation ☐ internal ☐ external ☐ both
Memory Recent: ☐ good ☐ fair ☐ poor Remote: ☐ good ☐ fair ☐ poor
Oriented X's 3 ☐ person ☐ place ☐ time
Attention Level ☐ focused ☐ distracted ☐ restless ☐ unfocused
Hallucinations ☐ no ☐ yes - if yes specify: _____
Delusional Thinking ☐ no ☐ yes – if yes specify: _____
Coping Skills ☐ good ☐ fair ☐ poor
Readiness for Treatment ☐ resistant ☐ willing ☐ eager ☐ desirous of help
Understanding of Addiction / Problems ☐ good ☐ some insight ☐ limited ☐ lacking
Reaction to interview ☐ cooperative ☐ friendly ☐ bored ☐ evasive ☐ hostile

CLINICAL EVALUATION

Present your clinical impression of the patient / client in narrative form. Do not reiterate data collected in the previous pages; rather, use the gathered information as a way to support your clinical assessment and conclusions.

Client's Presenting Problems, Underlying Issues and Negative Factors that may impact treatment:

Patient Label

Client's strengths, assets, and available support systems and how they may relate to or impact treatment:

Client's coping mechanisms and how they may relate to or impact treatment:

Client's attitude towards treatment:

Aftercare plans and concerns:

Overall impressions and conclusions: (Reference PTSD, ACE & BECK scores to support conclusion)

Staff Signature:_____ Date: _____

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