Consumer Services, Inc.
Taylor Life Center

Psychosocial Assessment (Adult) – Initial Assessment

Consumer Name: _____ **Date of Birth:** _____

1. **Name of person completing form (if other than consumer):** _____

   Relationship to consumer: _____

   If a guardian please identify what type of guardianship*: ☐ Family Guardian ☐ Public Guardian
   **Proof of guardianship required for treatment*

2. **Please check the box that best defines your current living situation:**
   - ☐ Homeless on street or in shelter
   - ☐ Private residence with family members
   - ☐ Private residence: alone, with spouse or with friends
   - ☐ Specialized residential home
   - ☐ General residential home
   - ☐ Prison/Jail/Juvenile Detention Center
   - ☐ Support independence program
   - ☐ Nursing home
   - ☐ Institutional setting
   - ☐ Other: _____

   Additional comments on current living situation:

3. **If you are living in private residence, please list the name of each member in the residence:**

Household Member Name	Relationship	Age	Quality of Relationship

Education:

4. **What is your highest level of education?** (Please check all that apply)
   - ☐ Completed less than high school
   - ☐ Completed high school or GED
   - ☐ Completed some college
   - ☐ Currently in school – K - 12th grade
   - ☐ Currently in training program
   - ☐ Currently in special education
   - ☐ Currently attending college
   - ☐ College graduate
   - ☐ Other: _____

Staff Name: _____
Case Number: _____

5. **Do you have a history of learning difficulties?** (Please check all that apply)
   ☐ No ☐ Mental Retardation ☐ Special school placement: _____
   ☐ Learning disability/type:_____ ☐ Other: _____

6. **Do you have any barriers to learning?**
   ☐ No ☐ Inability to read or write ☐ Other: _____

7. **What is your primary spoken language?** ☐ English ☐ Spanish ☐ Other:_____

8. **Do you have any special communication needs?**
   ☐ No ☐ TDD/TTY Device ☐ Sign Language Interpreter ☐ Other assistive technology
   ☐ Assistive Listening Device ☐ Language Intrepreter Services needed/other spoken language: _____

Employment

9. **What is your current level of employment?** (Please check all that apply)
   ☐ Employed full-time (greater than 30 hrs/week)
   ☐ Employed part-time (less than 30 hrs/week)
   ☐ Unemployed, but looking for work and/or on layoff from job
   ☐ Unemployed, not looking for work (homemaker, student, institutionalized)
   ☐ Sheltered workshop or work services participant in non-integrated setting
   ☐ Retired from work
   ☐ Not working – under 18
   ☐ Volunteer/unpaid work
   ☐ Other: _____

   If employed, please write the name of your employer:_____

10. **Are you satisfied with your current job?** ☐ N/A ☐ No ☐ Yes
11. **If you are not currently working, do you want to work?** ☐ No ☐ Yes
12. **Are you experiencing financial problems?** ☐ No ☐ Yes
13. **Are you concerned employment will affect any financial benefits you are receiving?** ☐ No ☐ Yes
14. **Have you been involved in supportive employment in the past?** ☐ No ☐ Yes
15. **Have you been involved in employment workshops?** ☐ No ☐ Yes
16. **Have you been involved in job coaching?** ☐ No ☐ Yes

Additional comments on employment, past or current skills/interests:

17. **Have you ever served in the United States military?** ☐ No ☐ Yes

If yes, describe branch of service, any pertinent duties, and any trauma experienced during services as applicable.

Type of Discharge (general/honorable/other): _____

Date of discharge: _____

Consumer Name: _____
DOB: _____
Staff Name: _____
Case Number: _____

Legal Status/Issues

18. Do you have a legal payee?

Name and address of payee: _____

Phone Number: _____

19. What is your current legal status?

- ☐ No legal issues
- ☐ Alcohol/drug related legal problems
- ☐ ATO (Alternative Treatment Order)
  End date of ATO: _____
- ☐ Conditional release
- ☐ Detention
- ☐ Outpatient commitment
- ☐ On probation
- ☐ On parole
- ☐ Awaiting charge
- ☐ Court ordered treatment
- ☐ Other: _____

20. Please list your history of legal charges, current legal charges, convictions, civil proceedings, domestic related court problems, and incarcerations, including length of incarcerations:

☐ Not applicable/No legal charges

Name of probation/parole officer: _____

Address: _____

Phone number: _____

How long on probation/parole: _____

21. Have you had any involvement in Juvenile Court related to child abuse, neglect or dependency?

Current: ☐ No ☐ Yes Explain: _____

Past: ☐ No ☐ Yes Explain: _____

22. Do you have child support enforcement orders? ☐ No ☐ Yes, please explain:

23. Has CPS been involved with your family? ☐ No ☐ Yes, please explain:

Name of CPS caseworker(s): _____

Consumer Name: _____
DOB: _____
Staff Name: _____
Case Number: _____

Physical Health

24. Name of Primary Care Physician: _____

Address: _____

Phone Number: _____

Other prescribing physician: _____

Address: _____

Phone Number: _____

25. Please explain your past medical, physical, psychiatric symptoms. List any physical limitations, illnesses, diagnoses, operations, hospitalizations (include dates), and/or medical concerns:

26. Do you have allergies or adverse reactions to any medications? ☐ No ☐ Yes, please list:

Consumer Name: _____
DOB: _____
Staff Name: _____
Case Number: _____

Medications:

27. Please list or include a copy of your current medications, including prescriptions, over-the-counter, herbal and vitamins: ☐ No medications

Medication	Rationale/ Purpose	Dosage/Route/Frequency	Prescribed by/ Date Prescribed	Do you take your medications as prescribed?		
				Yes	No	Sometimes
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
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Consumer Name: ____________________
DOB: ____________________
Staff Name: ____________________
Case Number: ____________________

28. Do you feel like your current medications are working? ☐ Yes ☐ No
If no, please explain which medications you feel are not working and why:

29. Please list your past psychotropic medications:

Psychotropic Medications	Reason for Discontinuation

30. Please explain any past mental health treatment history:

Outpatient mental health: ☐ Not applicable/No treatment

Name of Agency	Dates of Service (From – To)	Clinician Name

Psychiatric Hospitalization/Residential Treatment Facilities: ☐ Not applicable/No treatment

Name of Hospital/Facility	Dates of Service (From – To)	Reason (suicidal, depressed, etc.)

31. Have you been previously diagnosed by a professional? ☐ No ☐ Yes, please explain:

STOP

The following sections are for clinician use only:

Consumer Name: _____
DOB: _____
Staff Name: _____
Case Number: _____

Taylor Life Center
Consumer Services, Inc.

Health Screening - Adult

Consumer Name: _____ **Date of Birth:** _____

Date: _____ **Age:** _____ **Height:** _____ **Weight:** _____ **Sex:** ☐ Male ☐ Female

1. **Please list any specialists that also provide your medical care:**

2. **Hospital of choice:** _____

3. **Please write the <u>most recent date</u> for the following medical appointments:**
   Medical check-up: _____
   Dental check-up: _____ Dentures: ☐ No ☐ Yes
   Eye examination: _____
   Hearing examination: _____

4. **List any illness that seem to run in your family:**

5. **Have you ever lost consciousness?** ☐ No ☐ Yes
   If yes, when: _____ Explain: _____

6. **Do you see your medical doctor on a regular basis?** ☐ No ☐ Yes

7. **Do you have any allergies?** ☐ No ☐ Yes
   If yes, please check as many as apply and list by name:
   ☐ Food ☐ Drugs ☐ Pollen ☐ Other:
   List: _____

8. **How many hours do you sleep each day?**

9. **How much of the following items do you consumer per day/per week?** (check day or week)
   Coffee: _____ ☐ Day ☐ Week Pop/soda: _____ ☐ Day ☐ Week Tea: _____ ☐ Day ☐ Week

10. **Do you smoke or use tobacco?** ☐ No ☐ Yes

11. **Were you ever treated for a sexually transmitted disease?** ☐ No ☐ Yes
    If yes, please check all that apply:
    ☐ Syphilis ☐ Gonorrhea ☐ Herpes ☐ **AIDS/HIV** ☐ Chlamydia ☐ Genital Warts ☐ **Hepatitis**
    Other: _____

Staff Name: _____
Case Number: _____

12. Have you ever been diagnosed with any of the following conditions?

☐ Cancer: Are you in remission? ☐ No ☐ Yes

☐ Organ failure (kidney, liver): Are you on dialysis? ☐ No ☐ Yes

☐ Congestive Heart Failure: Do you wear a pacemaker? ☐ No ☐ Yes

☐ COPD (Emphysema, Chronic Bronchitis) ☐ No ☐ Yes

☐ Tuberculosis ☐ No ☐ Yes Date of treatment: _____

13. Are you on a special diet? ☐ No ☐ Yes

If yes, explain: _____

14. Do you have difficulty swallowing? ☐ No ☐ Yes

If yes, explain: _____

15. Check any of the following that apply to you now or in the past: (N=now, P=past)

N	P		N	P		N	P	
☐	☐	Headaches	☐	☐	Hearing impaired	☐	☐	Chest pains
☐	☐	Dizziness	☐	☐	Blackouts	☐	☐	Heart attack
☐	☐	Fainting	☐	☐	Blurred vision	☐	☐	Stroke
☐	☐	Stomach trouble	☐	☐	Memory loss	☐	☐	Blood clots
☐	☐	No appetite	☐	☐	Sexual problems	☐	☐	Ulcers
☐	☐	Eat too much	☐	☐	Confused thoughts	☐	☐	Hypoglycemia
☐	☐	Constipation	☐	☐	Low blood pressure	☐	☐	Tremors/shaking
☐	☐	Diarrhea	☐	☐	Menstrual problems	☐	☐	Back problems
☐	☐	Shy/sensitive	☐	☐	Anemia	☐	☐	Urinary infections
☐	☐	Sleep too much	☐	☐	Arthritis	☐	☐	Unable to relax
☐	☐	Insomnia	☐	☐	Lacks energy	☐	☐	Wounds (currently open)
☐	☐	Lung problems	☐	☐	Gout	☐	☐	Cholesterol
☐	☐	Bruises easily	☐	☐	Rashes	☐	☐	Thyroid
☐	☐	Hernia	☐	☐	Hot or cold spells	☐	☐	Closed head injury
☐	☐	Concussion	☐	☐	Sinus	☐	☐	Anxiety/panic

Please explain: _____

16. Please list or include a copy of the your current medications, including prescriptions, over-the-counter, herbal and vitamins: ☐ No medications

Medication	Rationale/ Purpose	Dosage/Route/Frequency	Prescribed by/ Date Prescribed	Do you take your medications as prescribed?		
				Yes	No	Sometimes
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

Consumer Name: _____

DOB: _____

Staff Name: _____

Case Number: _____

17. Health Conditions (Please check all that apply)

Hearing (Ability to hear with hearing appliance normally used)

☐ Adequate ☐ Minimal difficulty ☐ Moderate difficulty ☐ Severe difficulty ☐ No hearing

Hearing aid used: ☐ No ☐ Yes

Vision (Ability to see with glasses or with other visual appliance normally used)

☐ Adequate ☐ Minimal difficulty ☐ Moderate difficulty ☐ Severe difficulty ☐ No vision

Visual appliance used: ☐ No ☐ Yes

Pneumonia

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.

☐ Information unavailable ☐ Other: _____

Asthma

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.

☐ Information unavailable ☐ Other: _____

Upper Respiratory Infections (RESP)

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.

☐ Information unavailable ☐ Other: _____

Gastroesophageal Reflux (GERD)

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.

☐ Information unavailable ☐ Other: _____

Chronic Bowel Impactions

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.

☐ Information unavailable ☐ Other: _____

Seizure Disorder or Epilepsy

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.

☐ Information unavailable ☐ Other: _____

Progressive neurological disease (Alzheimer's/Dementia, etc.)

☐ Not present ☐ Treated for condition within past 12 mos. ☐ Information unavailable

☐ Other: _____

Diabetes

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.

☐ Information unavailable ☐ Other: _____

Hypertension

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.

☐ Information unavailable ☐ Other: _____

Obesity

☐ Not present ☐ Medical diagnosis of obesity present or Body Mass Index (BMI) > 30

☐ Other: _____

Consumer Name: _____

DOB: _____

Staff Name: _____

Case Number: _____

18. Do you have any medical need currently requiring attention? ☐ No ☐ Yes

If yes, explain: _____

Client/Guardian Signature: _____ Date: _____

Medical professional review and comments/recommendations:

Medical professional signature: _____ Date: _____

Clinician signature: _____ Date: _____

☐ Based on self-report, a referral for a Physician Health Assessment will be made to: _____

☐ Based on self-report, a referral to a health care practitioner will be made.

Consumer Name: _____

DOB: _____

Staff Name: _____

Case Number: _____