Psychosocial Assessment

Patient/Client Name: _____ DOB: _____

Source of Referral: _____

Presenting Issues: _____
_____
_____
_____
_____

Medical Diagnosis: _____
_____

Functional Status: □ Independent □ Needs assistance □ Total dependence □ Other _____

Does patient have an Advance Directive and/or Health Care Proxy? □ Yes □ No
Details: _____
_____
Has a copy been obtained and placed on the patient's chart? □ Yes □ No

Appearance: □ Neat/Groomed □ Disheveled/Unkempt □ Other _____
Mood: □ Pleasant □ Calm □ Angry □ Tearful/Upset □ Depressed □ Anxious □ Other _____
Affect: □ Appropriate □ Flat □ Sad □ Content □ Indifferent □ Other _____

Family/Support System
Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Other _____

Children: □ Yes □ No Details: _____
_____

Family Adjustment:
Are family members/support person, spouse and children, involved in patient's treatment? Are they supportive? _____
_____
_____

Do family members need support in adjusting to patient's diagnosis? □ Yes □ No
_____

Living Environment: □ Alone □ With spouse/family □ Nursing home □ Shelter □ Homeless
Other/Details: _____

Other/Additional Support Systems: _____
_____
_____
_____

Source of Income: □ Employment □ Welfare/General Assistance □ Supported by Others □ Disability □ Other
Details: _____

Employment History: □ Employed □ Retired □ Temporarily Disabled □ Permanently Disabled
Details: _____
_____

Insurance: □ Private Insurance □ Medicare □Medicaid □ Charity Care □ None
Details: _____
Prescription Coverage: _____

History of Substance Use: □ Yes □ No □ Smoking □ Alcohol □ Drugs
Details: _____
_____

History of Mental Health: □ Yes □ No
Details: _____
_____

Religion/Spiritual/Cultural Identity:
Ethnic or Cultural Affiliations: _____
_____
_____

Religious Affiliations/Spirituality: _____
_____
_____

Hobbies, Interests, Additional Strengths: _____
_____
_____

Patient's Overall Coping with Diagnosis □ Good □ Fair □ Poor
Have you ever experienced any of the following in relation to your diagnosis?
□ Anxiety □ Depression □ Anger □ Substance Use □ Suicidal or Homicidal Thoughts
Details: _____
_____

Narrative/Notes: _____
_____
_____
_____
_____
_____
_____

Goals for Social Work Intervention:

1. _____
2. _____
3. _____

Referrals Made:

_____
_____
_____
_____
_____

Oncology Social Worker Signature _____ **Date** _____