

Psychosocial Assessment Worksheet

EDC (if indicated): _____

Name: _____
Date of Service: _____ CHR #: _____

Psychosocial Assessment - Circle "Y" es or "N"o as appropriate	Notes
Social Supports	
N Y Good relationship with partner	
Y N Family violence	
N Y Good support system	
N Y Good relationship with relatives	
Community Supports	
N Y Transportation adequate	
Y N Legal assistance needed	
N Y Attends/member of church	
Y N Needs referral for community service	
Shelter/Nutrition	
Y N Homeless or soon to be evicted	
N Y Dwelling safe and sanitary	
N Y Utilities connected	
Y N Lives alone	
N Y Adequate food	
N Y Home telephone/message telephone	
Economic Status	
N Y Employed	
N Y Adequate income	
N Y Adequate budgeting	
Y N Public benefits needed	
Educational Needs	
Y N Limited or incomplete education	
Y N Language or literacy barrier	
Y N History of special education	
N Y School age children attending school	
Emotional /Physical Health	
Y N Mental health problems	
Y N Drug, alcohol use/abuse	
N Y Good physical health	
Y N Tobacco use	
Pregnancy Issues	
Y N Current pregnancy fears/anxiety	
Y N Incest or rape victim	
N Y Satisfactory family planning	
N Y Parenting experience	
N Y Child care plan	
Y N Considering alternatives to pregnancy	
N Y Understands importance of prenatal care	
Y N Problems with previous pregnancies	
Y N Late registrant for care	
Y N Adolescent mother	
HIV & Aids Issues	
Y N Needs referral to doctor/clinic	
Y N HIV symptoms	
Y N Other HIV & family members/partner	
N Y Understands/Practices safer sex	
N Y Medicaid/Health insurance/VA benefits	
N Y Physical/Emotional support available	
Y N Needs financial assistance with medications	
Child Health Issues	
Y N Needs referral to doctor/specialty clinic	
N Y Age-appropriate development	
Y N Medical symptoms/crises	
N Y Good understanding of medical condition	
Y N Needs financial assistance w/ medication/formula	