**Guidelines for Psychosocial Assessment**

1. Talk with a patient and establish a meaningful interaction.
2. Once you have conducted your assessment please complete the following attached assessment form – Submit a typed report (ideally you would download the word document and enter your data directly into that document distinguishing your work from the original document either in bold lettering or a different color of font; a process I will refer to throughout the rest of this document as “highlight”.
3. In sections where there are lists of descriptors you may simply highlight those that apply to your patient*. If none of the descriptors apply you must state this is so*. For example: Does the patient have any of the following? **The patient does not display any abnormal motor activity.**
4. In sections where a question is asked you may reply **yes** or **no.**  If yes provided an explanation. For example: History of running away/truancy? **No.** or ‘**Yes, the patient has run away from home twice; once at age 12 for a week and once at age 15 for two months.’**
5. Please note some sections will provide you with a list of descriptors and will also ask you to describe the areas which are positive. For example: Is the patient delusional? **Yes.** If so what kind of delusion is the patient experiencing? Describe. **Highlight and then describe the delusion i.e. ‘paranoid: the patient believes people are watching him and have cameras and microphones hidden in his home.’**
6. Note some sections allow for the selection of all descriptors that apply. Simply highlight all descriptors that apply.
7. Remember the MSE is a snap shot of the patient’s current mental status (not past history) i.e. the patient’s mental “vital signs”.
8. The prognosis is your estimation, based on all the information you have gathered, of the patient’s future mental health.
9. For the priority concept - write ***individualized*** interventions (2-3), a short-term goal (what could be accomplished in a shift or the time you will have the opportunity to interact with this patient), and a related long-term outcome.
10. Using the information you gathered in your assessment, write a nurses note about the patient’s history and status. The note ***must*** contain information about the patient’s current problem/symptoms, current mental status, medical (medicine) treatments, and immediate safety risks (including observation level). Choose the most pertinent information and be concise. Focus on psychiatric issues.
11. Attach AIDES medication sheets for each of your patient’s psychotropic medications.

**Nursing 411**

**Psychosocial Assessment Tool**

Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note: Points are show in bold in parentheses**

# Introduction (20)

**(1**) Date of Assessment:

**(1)** Source of Information:

**(1)** Date of Admission:

Diagnoses:

1. Psychiatric DX (**1)**
2. Medical DX **(1)**
3. Psychosocial Issues **(1)**

**(2**) Chief Complaint [primary reason patient is in treatment/hospitalization right now]:

**(3**) History of Present Illness [events leading up to treatment/hospitalization]:

**(3)** History of Past Illness [pertinent events in patient’s past i.e. psychiatric hospitalizations, suicide attempts, outpatient therapy, substance abuse, pertinent medical history, etc.].

**(3)** Family History [pertinent events in patient’s family history; note family psychiatric history if known i.e. diagnoses, suicide completion, substance abuse, etc.]

**(3)** Psychoactive Medications *[AIDES sheets for each]*:

# Demographics (10)

### DEMOGRAPHIC DATA: (1/2 each)

Patient Initials: Years of Education: Age:

Religion: Marital Status: Race:

Occupation: Able to read/write: Gender:

Allergies: Sexual orientation:

### Support Systems: (1/2 each)

1.

2.

3.

### (1) Special Dietary Concerns:

### (1) Number of Living children [include gender, age and health status]:

### (1) Living Arrangements:

# Cultural & Social (20)

## CULTURAL AND SOCIAL HISTORY:

### (2) Health beliefs and practices [personal responsibility for health; special self-care practices]:

### Religious/spiritual beliefs and practices [Use HOPE questions]:

|  |  |
| --- | --- |
| H  ***Sources of Hope*** | What are your sources of hope?  What spiritual resources bring you comfort? |
| O  ***Organized Religion*** | Are you a member of a faith community or religion?  What religious practices are important to you? |
| P  ***Personal Spirituality*** | Do you have personal spiritual beliefs that are separate from organized religion/faith?  What spiritual practices are most helpful to you? |
| E  ***Effects on care*** | Is there any conflict between your beliefs and the care you are receiving?  Do you hold beliefs that you believe may affect your care?  Do you wish to consult/speak with a religious or spiritual leader? |

### (2) Significant losses/changes [what, when occurred]:

### (2) Significant relationships:

### (2) Hobbies/interests [how is leisure time spent, any recent changes?]:

### (3) Previous pattern of coping with stress [what have you done before that seems to have helped; what have you tried that hasn’t worked for you?]:

### (2) Use of street drugs/alcohol [type, amount, frequency, last use]:

### (2) Smoking or other tobacco use [type, frequency, how long]:

### (2) History of running away/truancy? Problems with impulsive behavior? Describe:

### (2) Other lifestyle factors contributing to present adaptation:

**Mental Status (30)**

## GENERAL DESCRIPTION: [REMEMBER, the mental status exam is your patients mental vital signs right now, not when they were admitted or in the past.]

### General Appearance: (2)

Describe the following:

* Grooming and dress
* Hygiene
* Posture
* Height
* Weight
* Eye contact
* Hair color
* Evidence of scars, tattoos, etc.

How does appearance compare with chronological age?

### Demeanor (General Attitude): (2)

Choose: *[Highlight or bold all that apply]*

* Cooperative or uncooperative
* Friendly or withdrawn
* Hostile
* Defensive
* Evasive
* Interested or uninterested
* Attentive or apathetic
* Guarded
* Fearful
* Anxious
* Calm
* Hypervigilant
* Other\_\_\_\_\_\_\_\_\_\_\_

### Motor Activity: (2)

Does the client have any of the following? *[Highlight or bold all that apply]*

* Tremors
* Tics
* Mannerisms/gestures
* Hyperactivity/psychomotor retardation
* Restlessness
* Rigidity
* Unusual gait pattern

If so, describe.

### Speech Patterns: (2)

Choose:  *[highlight or bold all those that apply]:*

* Clear
* Spontaneous
* Slurred
* Mumbling
* Slow
* Hesitant
* Soft
* Hyperverbal
* Rapid
* Pressured
* Loud
* Other \_\_\_\_\_\_\_\_\_\_\_

### Orientation: (1)

Is the patient oriented? *[highlight or bold all those that apply]:*

* Person
* Place
* Time
* Situation

### Mood: (2)

Patient’s mood *[self-described, in quotes]:*

### Affect:

**(1)** Patient’s affect *[assessed by observation, highlight or bold all that apply]:*

* Pleasant
* Bright
* Euphoric
* Neutral
* Sad
* Depressed
* Apathetic
* Angry
* Anxious

**(1)** Range of affect *[highlight or bold the appropriate range level]:*

* Flat
* Blunted
* Full
* Exaggerated
* Labile

**(1/2)** Is affect appropriate to content of speech/circumstances? *[highlight or bold]* Yes or No

**(1/2)** Are mood and affect congruent? *[highlight or bold] Yes* or No

### Thought Processes and content:

**(1)** Form of thought*: [Highlight or bold all that apply]*

* Logical or illogical
* Coherent or incoherent
* Other:
* Goal-directed
* Circumstantial
* Tangential
* Loose associations
* Flight of ideas
* Rambling
* Thought blocking

**(1)** Is the client able to concentrate? *[highlight or bold]* Yes or No

**(1)** Content of thought: *[highlight or bold]*

Is the client delusional? Yes or No

If so what kind of delusions is the client experiencing? *[highlight or bold]*

Then **DESCRIBE.**

* Paranoid?
* Grandiose?
* Religious?
* Referential?
* Somatic?
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(1)** Are any of the following present? *[highlight or bold]*

Then **DESCRIBE**

* Obsessions?
* Ruminations?
* Phobias?
* Magical thinking?
* Depressive cognitions?
* Guilt?
* Worthlessness?
* Hopelessness?
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(1)** Is there any type of perceptual disturbance? *[highlight or bold] Yes* or No

If so what type? Describe.

* Auditory hallucinations?
* Visual hallucinations?
* Tactile hallucinations?
* Olfactory hallucinations?
* Gustatory hallucinations?

**(1)** Is the patient currently experiencing suicidal ideation? *[highlight or bold]* Yes or No

If yes answer the following:

If so does the patient have a plan? Yes or No, if yes describe.

If so does the patient have the means? Yes or No, if yes describe.

If so does the patient have the intent? Yes or No, if yes describe.

**(1)** Is the client currently experiencing homicidal ideation? *[highlight or bold*] Yes or No If yes answer the following:

If so does the patient have a plan? Yes or No, if yes describe.

If so does the patient have the means? Yes or No, if yes describe.

If so does the patient have the intent? Yes or No, if yes describe.

**(1)** Does the patient practice non-lethal self-harm behavior? *[Highlight or bold all that apply]*

* Cutting
* Burning
* Picking
* Pinching
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time the patient self-harmed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What does the patient perceive is achieved by this practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Memory: (1)

Is the patient’s memory intact? *[Highlight or bold all that apply]*

Based on what evidence?

* Recent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Remote \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there evidence of confabulations? *[highlight or bold] Yes* or No

### Cognitive Ability:

**(1)** Is the patient concrete or abstract to: *[highlight or bold]*

* Similarities? Yes or No
* Opposites? Yes or No
* Proverbs? Yes or No

1. Is the patient’s intellect below average, average, above average? Based on what evidence?

*[highlight or bold]*

* Able to read and write.
* Spell WORLD forwards and backwards
* Subtract serial 7s from 100
* Knowledge of current events

**(1)** Can the patient? *[highlight or bold]*

* Solve problems? Yes or No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Make decisions? Yes or No Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(1)** Is the patient aware? *[highlight or bold]*

* Of limitations? Yes or No Based on what evidence? \_\_\_\_\_\_\_\_\_\_\_\_
* Of consequences? Yes or No Based on what evidence? \_\_\_\_\_\_\_\_\_\_\_
* Of illness? Yes or No Based on what evidence? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(1)** Does the patient exhibit the use of defense mechanisms? Yes or No

If so which ones? *[highlight or bold]* Describe.

* Projection
* Suppression
* Undoing
* Displacement
* Intellectualization
* Rationalization
* Denial
* Repression
* Isolation
* Regression
* Reaction Formation
* Splitting
* Religiosity
* Sublimation
* Compensation

### Judgment: (1)

How would you describe the patient’s judgment? *[highlight or bold]*

* Good
* Fair
* Poor

Based on what evidence*? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

### Insight: (1)

How would you describe the patient’s insight into their mental health? *[highlight or bold]*

* Good
* Fair
* Poor

Based on what evidence? *[Do they know their diagnosis? Do they their medications? Are they compliant with treatment*?] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Prognosis (5)

Calculate your patient’s SAD PERSONS risk score: [A score of 0-2 = little risk; 3-4 = close observation; 5-6 = consider hospitalization; 7-10 = hospitalize or commit (risk is very high)]

* **S**ex: Male = 1; Female = 0
* **A**ge: 25 – 44 or 65 and older = 1; All other ages = 0
* **D**epression: Present = 1; Absent = 0
* **P**revious suicide attempt: Present = 1; Absent = 0
* **E**TOH abuse: Present = 1; Absent = 0
* **R**ational thinking: Psychosis present = 1; Psychosis absent = 0
* **S**ocial support: Absent (or recent loss of significant other) = 1; Present = 0
* **O**rganized plan: Has plan w/lethal method = 1; No plan or method non-lethal = 0
* **N**o spouse (or significant other): If divorced, widowed, separated or single (males) = 1; Married or presence of a significant other = 0
* **S**ickness: If chronic, debilitating, severe (non-localized CA, epilepsy, MS, or GI disorders) = 1; Significant sickness absent = 0

**(1)** Your patient’s SAD PERSONS risk score is: \_\_\_\_\_\_\_\_\_\_

**(2)** What should be your response based on your patient’s score?

**(2)** What is your perception of this patient’s prognosis? What will affect the outcome?

# Nursing Care (15)

### Priority Nursing Concept: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(2)** Short-term goal [to be accomplished during your shift]:

Interventions [implemented to accomplish goal] **(1 each)**

1.

2.

3.

**(1)** Outcome [was the goal accomplished]

### Secondary Nursing Concepts [list a minimum of 2] (1 each for the first 2)

1.

2.

3.

4.

### Nurses Note: (7)

Write a narrative-nursing note for this patient as if you were preparing report for the next shift or for the patient’s psychiatric provider *[use the 411 SBAR report as a guide].*