



Comprehensive Client Assessment

Patient Name: _____ Date of Visit: _____

DOB: _____

I. Social Network:

<u>Name</u>	<u>Resides Near (Y/N)</u>	<u>Relationship</u>	<u>Supportive Relationship (Y/N)</u>
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II. ADL/IADL

III. Environment:

A. Current Residence/ Time Frame/Condition:

B. Prior Residence(s)/Condition:



IV. Community Involvement:

<u>Agency</u>	<u>Services Provided</u>	<u>Comments</u>
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VII. Financial & Benefit Resources:

- A. Income Sources: _____
 - B. Savings & Asset Sources: _____
 - C. Own Home Yes: _____ No: _____ Comments: _____
 - D. Durable POA Yes: _____ No: _____ Comments: _____
 - E. Health Care Proxy Yes: _____ No: _____ Comments: _____
 - F. Insurance: Medicare: __ Medicaid: ____ BC/BS Type: _____ LTC: _____
- SSI: _____ other: _____

A. Work History: Veteran: Yes: _____ No: _____

B. Cultural/Generational/Racial/Ethnic/Gender Identity/Socio-Economic Factors:

C. Spirituality:

D. Health/Medical:

Drug & Alcohol, Tobacco Use Hx: Yes: _____ No: _____

Psycho/Bio/Social Functional Status: Behavioral Health Dx: Yes: _____ No: _____



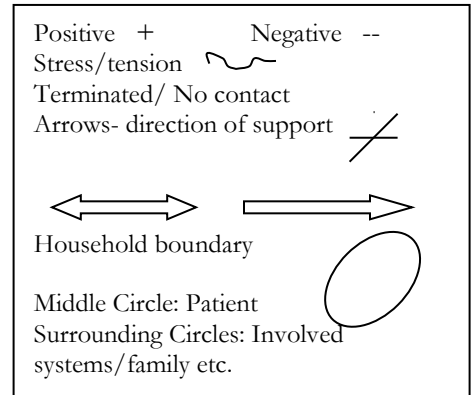
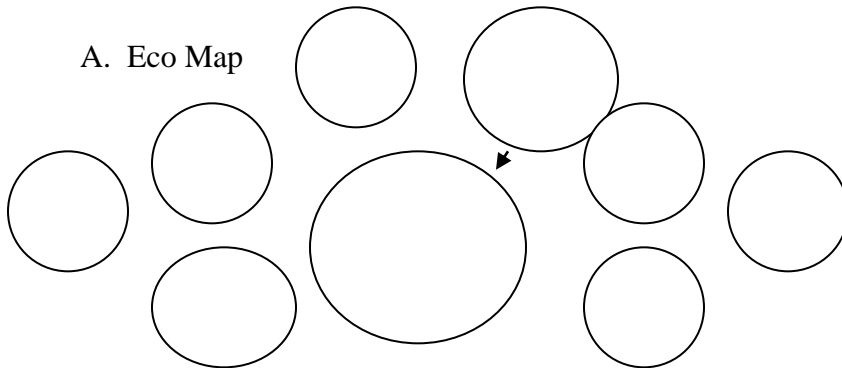
E. Additional Life Events:

Screenings Completed:

LEST
CAGE-AID
ACE
GDS
GAD

F. Social Work Assessment Summary:

A. Eco Map





G. Genogram



Social Work Psycho/Social Summary

Client/Family Strengths:

Client/Family Strengths:	
Summary of Goals & Desired Outcomes	Recommendations