

Psychosocial Assessment for Youth at Risk of Residential Placement

Date of Assessment:	
Personal Information	
Name:	
Age:	
Date of Birth:	
Gender:	
Race/Ethnicity:	
Home Address:	
Legal Guardian Email Address:	
Phone Number:	
Emergency Contact:	
Presenting Problem:	
Presenting Problem	
Brief description of the reason for referral and current concerns. (Include Current Location of Member)	
Family Background	
Family composition and dynamics.	

History of abuse, neglect, or trauma within the family.	
Current living situation and support systems.	
Education	
School attendance and performance.	
Special education needs, if any.	
History of suspensions, expulsions, or truancy.	
Social/Peer Relationships	
Peer group involvement.	
History of conflicts or violence with peers.	
Supportive relationships outside the family.	
Mental Health History	
Previous diagnoses (if any) and treatment.	
List Previous Treatment Providers and Dates of Service	
Current mental health symptoms and behaviors (Last 30 Days).	

History of self-harm, suicidal ideation, or suicide attempts.	
Substance Use	
History of substance use.	
Frequency and type of substances used.	
Impact of substance use on daily functioning.	
Legal Involvement	
Past or current legal issues.	
Involvement with juvenile justice system.	
Probation or court orders, if applicable.	
Medical History	
	
Any chronic medical conditions or disabilities.	
Current medications and compliance.	
History of hospitalizations or medical treatments.	
Name and Contact Info for Current PCP	
	1

Resources, Strengths and Protective Factors

Positive qualities, skills, or interests of the youth. Supportive relationships or resources. Coping strategies utilized in challenging situations. FAPT Involvement (Include Contact Info) Risk Factors Factors contributing to the risk of residential placement. History of violence, aggression, or self-destructive behaviors. Lack of stable housing or caregiver. Level of Care Recommendations/Interventions What level of care is the legal guardian and youth requesting LMHP Diagnostic Impression and Recommendations Physician Recommended Level of Care (include Name and contact number of physician): Referral for further assessment or treatment. Recommendations for therapy, counseling, or psychiatric evaluation.		
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Suggestions for family support services or community resources.		
Signature:	_	
Date:		