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	

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.	

Suggestions for family support services or community resources.	

Signature:____________________________________

Date:_______________________________________