|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | https://myevolvhillside.netsmartcloud.com/images/PrintHS.pngPrint | https://myevolvhillside.netsmartcloud.com/images/PrintPreviewHS.pngPreview | https://myevolvhillside.netsmartcloud.com/images/PrintSetupHS.pngPage Setup | https://myevolvhillside.netsmartcloud.com/images/person.gifHide Client Info | https://myevolvhillside.netsmartcloud.com/images/notes.gifHide Form Header | https://myevolvhillside.netsmartcloud.com/images/openHS.pngSelect Logo |  | https://myevolvhillside.netsmartcloud.com/images/close.pngClose | |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | |  | Hillside Family of Agencies  HFA Bio-Psychosocial History v2 |  | | **Client:** zzTEST, TESTINGg **DOB:** 05/29/2002 **Gender:**Male **ID#** 00901469 **Intake:** 10/06/2008 08:00am | | | | | **HFA Bio-Psychosocial History** | | | | |  |  | | --- | --- | | Client: |  | |  |  | | |  |  | | --- | --- | | Event: |  | |  |  | | |  |  | | --- | --- | | Actual Date: |  | |  |  | | |  |  | | --- | --- | | Staff: |  | |  |  | | |  |  | | --- | --- | | Approval Sent To: |  | |  |  | | |  | | --- | | HFA Bio-Psychosocial History: | | **Note: A psychosocial from another service/affiliate or agency may be used if it is written within the last year. Review the prior Psychosocial, signing and dating that the information is accurate. Update any areas not covered on the prior Psychosocial on this form. Update this evaluation when any changes occur or minimally on an annual basis. Be sure to address all areas including items listed in parentheses. Do not use N/A.**  **I. Reason for Referral (Include referring agency/funder name):**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Reason for Referral: |  | | |  |   **II. Source of Information**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Source of Information: |  | | |  |   **III. Legal Status**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Check all that apply: |  | | | https://myevolvhillside.netsmartcloud.com/images/config_square.gifOMH/Vol https://myevolvhillside.netsmartcloud.com/images/config_square.gifLDSS/Vol https://myevolvhillside.netsmartcloud.com/images/config_square.gifPINS/JD https://myevolvhillside.netsmartcloud.com/images/config_square.gifNeglect https://myevolvhillside.netsmartcloud.com/images/config_square.gifFreed https://myevolvhillside.netsmartcloud.com/images/config_square.gifCSE https://myevolvhillside.netsmartcloud.com/images/config_square.gifSelf-Supporting https://myevolvhillside.netsmartcloud.com/images/config_square.gifOther - (Provide Details Below) |  |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | "Other" Legal Status |  | | |  |  |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Legal Status Expiration Date: |  | | |  |   **IV. Treatment History (including HSA & non-HSA agencies, past Psychiatric Hospitalizations)**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Treatment History: |  | | |  |   **V. Family Background**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | A. Family Composition (Parents' names and current relationship with child , current living arrangements, family composition: number of & ages of siblings, birth order, nature of parent/sibling relationships, child's social and physical environment, visitation plan) |  | | |  |  |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | B. Family Strengths (external supports, extended family support, community supports, involvement in treatment, employment/financial stability, public assistance-if applicable, recreational and leisure activity, etc.) |  | | |  |  |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | C. Family Stressors (illness, hospitalizations, deaths, grief & bereavement, divorce, substance abuse, addictive behaviors, sexual abuse, children placed out of home, legal problems, domestic violence, physical / emotional abuse, neglect of family members, etc.) |  | | |  |   **VI. Cultural Background (primary language, race, ethnicity- how do these areas impact the client's service needs)**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Cultural Background: |  | | |  |   **VII. Religious Background (religious/spiritual beliefs and practices)**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Religious Background: |  | | |  |   **VIII. Education / Vocational History - Current School Information (academic/behavioral concerns, interactions with teachers/peers, CSE classification, IQ, Projective testing needed)**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Education / Vocational History : |  | | |  |   **IX. Client Development and Health (prenatal birth information, labor/delivery complications, developmental milestones, developmental delays)**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Client Development and Health: |  | | |  |   **X. Mental Status Exam (Describe client's current mental status including: appearance, behavior, mood and affect, speech, cognition, thoughts, perception, insight and judgement)**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Mental Status Description |  | | |  |   **XI. Sexual Development (e.g. how did client learn about sex and what age at first exposure? history of sexual experiences [pleasant, unpleasant and abusive], current sexual practices and preferences, level of knowledge regarding sexual reproduction and STDs, experience of touch & intimacy in the family, boundaries around sex in the home.)**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Sexual Development: |  | | |  |   **XII. Client's Medical Information (List hospitalizations w/dates, injuries, allergies, medication history, current health/medications, address any emergency health needs(if applicable)**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Client's Medical Information: |  | | |  |   **XIII. Client Strengths (talents, activities, creativity, motivations, resources, is he/she self-supporting, support systems-formal & informal, etc.)**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Client Strengths: |  | | |  |   **XIV. Client Psychosocial Stressors (history of verbal/ physical abuse, neglect, domestic violence, imminent danger or risk to harm to self or others, borderline intelligence, speech or hearing impairment, poor social & living skills, grief/bereavement)**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | A. Diagnosis (if available): |  | | |  |  |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | B. Substance and non-substance abuse (alcohol, drugs, other addictive behaviors) Note: Substance abuse- if the screening indicates an assessment is needed, you must refer client. |  | | |  |   **XV. Needs/Recommendations/ Treatment Interventions (What are the recommendations and/or treatment interventions for service planning based on the needs of the child/family. If treatment will not be provided by an HSA Service Provider who will you refer the client to and when. If deferring ?why?)**   |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | Needs/Recommendations/Treatment Interventions: |  | | |  |   **Note: Needs/Recommendation gathered during this evaluation must transfer to the Initial Service Plan and Comprehensive Service Plan.** | |  |  | | **Scanned Document (External Bio-Psychosocial)** | | | | |  |  | | --- | --- | | Scan External Bio-Psychosocial If Applicable: | No document attached | |  |  | | **Service Related Encounter Information** | | | | |  |  | | --- | --- | | Program Providing Service: |  | |  |  | | |  |  | | --- | --- | | Facility Providing Service: |  | |  |  | | **Progress Note** | | | | |  | | --- | | Progress Note: | |  | |  |  | | **Tasks/Schedules** | | | | |  |  | | --- | --- | | Next Event Due: |  | |  |  | | |  | | --- | | *Next Scheduled Event* | |  |  | |  |  |  | |