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SOCIAL WORK CONSULT

Date: ____/____/____ Time: ______________________

CLIENT NAME: ________________________________ DOB: ____/____/______ Age:__________
Marital status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married

REFERRAL:
Referral Source/Reason: ____
Person(s) Interviewed: ____

Presenting complaint: ____
____
____

FAMILY/LIVING ARRANGEMENTS:
Relationship (Spouse/Significant Other name & age/How long?): ______________________________
Children/dependents (names, ages): ____
Current Living Arrangements (location, household members): ________________________________
____
____
____
Accessible? ☐ Yes ☐ No ____
Safety/Supervision needs: ☐ Yes ☐ No ____
Phone: ____
Transportation: ____
Concerns/Needs: ____
____

HEALTH/MEDICAL:
Concerns/Needs ____
____
Current health issues: ____
____
Allergies: ____
Health hx: ____
____
Surgical hx: ____
Medications: ____
____
Pain: ____
Diet/Nutritional: ____
Tobacco use:____
Alcohol/Drug use: ____
Equipment: ____
____

RESOURCE/FINANCIAL:
Concerns/Needs ____
____
Personal Income: ____
Other household income: ____

160b

PT.

MR.#/RM.

DR.

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Monthly expenses:____
Assistance Programs: (Established /Pending/Referral made/Info)
☐ DHS: Est Pend Ref ☐ Financial Assistance ☐ Food Stamps ☐ Medicaid
____
☐ VA: Est Pend Ref ____
☐ Social Security: Est Pend Ref ☐Retirement ☐SSDI ☐SSI ☐Medicare
____
☐ Other: ____
Insurance: ____
Prescription coverage: ____

COMMUNITY RESOURCES:
Concerns/Needs: ____
____

Referrals for:
☐ Food
☐ Clothing
☐ Shelter
☐ Utilities
☐ Transportation
☐ Home Care
☐ Respite Care
☐ Domestic violence
☐ 12 Step
☐ Child/Family
☐ Support Groups
☐ Counseling

SOCIAL/EMOTIONAL:
Observations of client (appearance, behavior, affect, mood,etc):
____
____
____
____

Emotional: ☐ Depression ☐ Anxiety ☐ Mood swings ☐ Suicidal ideation ☐ Loss/grief ☐ PTSD sx
☐ Pain ☐ Sleep disturbance ☐ Irritability ☐ Anger/temper ☐ Self injurious behaviors
☐ Alcohol/substance abuse problems ☐ Addictive behavior patterns ☐ Interpersonal conflicts/issues
Stressors: ____
History/Treatment: ☐ Mental health ☐ Substance abuse ______________________________________
____
____
Coping skills: ____
Support System: ____
____

Understanding of condition: ____
____
Education Needs: ____
____
Adjustment to condition: ____
____
____
____
____
Concerns/Needs ____
____

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Assessment: ____

Plan/Recommendations: ____

____ ____________________
Social Worker Date

Follow-Up Notes:

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