**SOCW 6200 Final Project: Bio-Psycho-Social Assessment**

Submit by Day 7 a 6- to 9-page paper that focuses on an adolescent from one of the case studies presented in this course. For this assignment, complete a bio-psycho-social assessment and provide an analysis of the assessment. This assignment is divided into two parts (Part A & Part B):

Part A: Bio-Psycho-Social Assessment: The assessment should be written in professional language and include sections on each of the following:

1. Presenting issue (including referral source)
2. Demographic information
3. Current living situation
4. Birth and developmental history
5. School and social relationships
6. Family members and relationships
7. Health and medical issues (including psychological and psychiatric functioning, substance abuse)
8. Spiritual development
9. Social, community, and recreational activities
10. Client strengths, capacities, and resources

Part B: Analysis of Assessment. Address each of the following:

* Explain the challenges faced by the client(s)—for example, drug addiction, lack of basic needs, victim of abuse, new school environment, etc.
* Analyze how the social environment affects the client.
* Identify which human behavior or social theories may guide your practice with this individual and explain how these theories inform your assessment.
* Explain how you would use this assessment to develop mutually agreed-upon goals to be met in order to address the presenting issue and challenges face by the client.
* Explain how you would use the identified strengths of the client(s) in a treatment plan.
* Explain how you would use evidence-based practice when working with this client and recommend specific intervention strategies (skills, knowledge, etc.) to address the presenting issue.
* Analyze the ethical issues present in the case. Explain how will you address them.
* Describe the issues will you need to address around cultural competence.

**BioPsychosocial History**

**[Template for Part A]**

Name:

Date:

Agency:

DEMOGRAPHIC INFORMATION

Age:

Ethnicity:

Marital Status:

Date of Birth:

PRESENTING ISSUE(S)

Client Self-Assessment of Problem(s)/Reason(s) for Seeking Treatment/Motivation Onset/Duration/Intensity/Frequency Precipitating Stressors/Stressful Events Symptoms (in Client’s/Informant’s Own Words)

REFERRAL SOURCE

Who referred this individual for treatment? Was the informant a reliable historian?

Was information gleaned from previous treatment records, court documents, etc.?

CURRENT LIVING SITUATION

Living Situation

Dependents/Care for Dependents Employment/Disability/Seeking Disability Income/Source of Income

Insurance Transportation Daily Living Skills

Social/Leisure Activities

Available Social Support

BIRTH AND DEVELOPMENTAL HISTORY

A. PRENATAL/BIRTH/DEVELOPMENT

Pregnancy and Labor Developmental Milestone(s)

B. EARLY CHILDHOOD

Family of Origin—Parents/Siblings/Extended Family, as Relevant

Geographic/Cultural/Spiritual Factors/as Relevant

Abuse/Trauma History

Physical/Emotional/Sexual Abuse History

SCHOOL AND SOCIAL RELATIONSHIPS

*This section should include information about social supports and the nature of those relationships; include current friendships, school/peer group experience, and military history, if applicable.*

A. SOCIAL DEVELOPMENT

Cultural/Peer Group/Environment School

Adolescence

B. EDUCATIONAL HISTORY

Public or Private School(s) Where Attended

Performance

Educational Level

Extracurricular Activities

C. MILITARY HISTORY What Branch

Duty Assignment (when/where) Rank/Discharge

FAMILY MEMBERS AND RELATIONSHIPS

A. SIGNIFICANT FAMILY RELATIONSHIPS

Family member and relationship

Relationship dynamics

B. INTERPERSONAL/MARITAL HISTORY

Age of Involvement in Relationships

Sexual Orientation

Length of Relationships

Relationship Patterns/Problems

Partner’s Age/Occupation

HEALTH AND MEDICAL ISSUES

A. MEDICAL HISTORY/HEALTH STATUS

History of Traumatic Injuries/Illnesses/Chronic Health Problems

Describe Current Illness

Is Client in Good General Health?

Is Client Allergic to Any Medications? Who Is Client’s Primary Care Physician?

Is the Client Being Treated by Any Other Physician(s)?

What Are the Client’s Current Psychiatric and Nonpsychiatric Medications?

Describe Client’s Health Habits: Appetite, Sleep, Exercise, Nicotine, Alcohol, Illicit Drugs, and Vitamins/Herbal Supplements?

Sexual Functioning: Preference/Problems

Pregnancy/Birth Control

Risk Behaviors for STDs

B. MENTAL STATUS

Attitude/Appearance/Behavior Affect/Mood/Psychomotor Activity

Orientation/Memory/Cognition Thought Process/Content Speech

Insight/Judgment Homicidal/Suicidal Ideation Hallucination(s)/Delusion(s)

C. HISTORY OF PSYCHIATRIC ILLNESS AND PREVIOUS TREATMENT

Previous Diagnoses/Medications/Inpatient and Outpatient Treatment History of Suicidal Ideation/Suicide Attempts/Self-Mutilation/Homicidal Ideation/Aggression

E. SUBSTANCE ABUSE HISTORY

Type/Onset/Duration/Amount Frequency/Pattern of Use Involvement in Treatment

SPIRITUAL DEVELOPMENT

Religion/spirituality

SOCIAL, COMMUNITY, AND RECREATIONAL ACTIVITIES

CLIENT STRENGTHS, CAPACITIES AND RESOURCES

Cultural/ethnic factors

Personal strengths

Family/social resources

OTHER SIGNIFICANT FACTORS

**SUMMARY**

PART B

After completing the biopsychosocial assessment in part A, analyze the assessment according to the questions in the assignment directions. Use APA and scholarly writing to complete this portion of the assignment.