

Psychosocial report

IDENTIFYING DETAILS

Surname _____ Name _____

ID no. _____ Nick name _____

Date of birth _____ Age _____

Race _____ Gender _____

Home language _____ Religion _____

Educational level _____ Marital status _____

Physical Address _____

_____ Code _____

Home telephone _____ Work Tel _____

Cell no. _____

Spouse and children's information

Name of spouse _____ Tel no. (h) _____

Cellphone _____

Tel no. _____

Next of kin (not living with patient)

Name: _____

Address: _____

Surname: _____

Relation: _____

Telephone (H/W): _____

Cell phone: _____

Surname: _____

Name: _____

ID/Date of birth: _____

Nickname: _____

Age: _____

Race: _____

Sex: _____

School: _____

Address: _____

Tel: _____

Parents information (Mother)

Name: _____

Address: _____

Surname: _____

Occupation: _____

Telephone (W): _____

Cell phone: _____

***Please provide proof of income (Certified)**

Parents information (Father)

Name: _____

Address: _____

Surname: _____

Occupation: _____

Telephone (W): _____

Cell phone: _____

***Please provide proof of income(Certified)**

Source of information:

1. _____
2. _____
3. _____

NATURE OF REPORT

FAMILY BACKGROUND

- **Family background and support systems:**

- **Main reason for needing a treatment program:**

- **Who is aware of your addiction?**

PHYSICAL AND PSYCHOLOGICAL ASPECTS

- **Physical / medical problems experienced?**

- **Psychological/Psychiatric**
- **Please indicate any previous psychological/psychiatric assessments and include report.**
- **Please note that as the referring Social Worker, should the service user present with any psychological/psychiatric problems or should we require a psychological assessment to be completed, it is the responsibility of the referring Social Worker and not iThemba Clinic.**

EDUCATION AND WORK BACKGROUND

HISTORY OF DEPENDENCY

- **Dependency history:**

This includes drugs used and treatment program followed before.

❖ CRIMINAL RECORD/ ANY PENDING CASES

RELIGIOUS ASPECTS

EVALUATION

CARE PLAN AND AFTERCARE:

RECOMMENDATIONS

Social Worker: _____

Signature: _____

Address: _____

Contact details: _____

Date: _____