

Psychosocial Case Study Format

I. Patient Identification

- a. **For confidentiality, write patient's name and hospital or clinic number, address and phone number on the separate contact form provided, which will be kept separate from the case study.**
 - i. Initials or pseudonym which will be used to refer to patient throughout case study report
 - ii. Age
 - iii. Race/Ethnicity
 - iv. Gender

II. Medical History

- a. Chief Complaint or major health problem at this time
- b. HPI
 - i. Include current medications at end of HPI
- c. Past Medical History
- d. Family Medical History
- e. Review of Systems

III. Psychosocial History

- a. **Demographic data** (Do not need to repeat identifying information stated above)
 - i. Marital status and history
 - ii. Sexual history and preference
 - iii. Education
 - iv. Occupational history
 - v. Socioeconomic status/financial situation
 1. Is the current illness creating financial distress?
 - vi. Religious affiliation
 - vii. Place of birth
 - viii. Anything unexpected or unique?

b. Family Genogram and APGAR

- i. Genogram
 1. Draw a genogram including three generations
 - a. Include all pertinent information
 - i. physical/mental illness
 - ii. nature of relationships within family
 - iii. Date of birth
 - iv. Date and cause of death
 - v. Date of marriage/separation/divorce
 - vi. Occupation
 2. APGAR
 - a. To be completed by patient and family members/significant others

c. Current problems or concerns

- i. What are they?
- ii. How distressing are the problems/concerns?
- iii. How long has the problems/concerns been occurring?

- iv. What strategies has the patient used to cope with/solve the problem?
- v. What is the incentive for change?
- vi. Any previous experiences similar to current problem?
- d. Background information**
 - i. How does the problem fit in the context of the genogram?
 - ii. If not addressed in the genogram, how does patient relate to others?
 - iii. Include any experiences that have or continue to have an effect on patient (i.e. enriched or impoverished experiences; traumatic events)
- e. Current life circumstances**
 - i. How does patient occupy his/her time?
 - ii. Include current psychosocial stressors, coping strategies, and resources
 - iii. Habits
 - 1. eating
 - 2. drinking
 - 3. smoking
 - 4. drugs
 - 5. caffeine
 - iv. Diet
 - v. Exercise
 - vi. Romantic/sexual attachments
 - vii. Close friends/support group
 - viii. Employment situation
 - ix. Strengths/areas of improvement
- f. Process Issues**
 - i. How does patient react to you?
 - ii. How does patient communicate his/her concerns (e.g. openly, honestly, avoids expressing feelings)?
 - iii. What is it like to be in the room with patient? What thoughts/emotions are evoked?
- g. Socioeconomic Environment**
 - i. Past education, occupation, religion, economic status, discipline, and housing while growing up
 - ii. Current
 - 1. economic status
 - 2. housing
 - 3. transportation
- h. Assessment**
 - i. Problem list from medical and psychosocial history
 - ii. Conclusions
 - 1. Conclusions should be a discussion of your assessment of the psychosocial functioning of patient as well as ways in which it interfaces with his/her organic disease and overall health. If this is not readily derived from the information collected, formulated answers to the following questions will complete this section.
 - 2. What is patient's view/model of the world?

3. What behaviors, excess or deficits, or attitudes does patient have that contribute to or alleviate his/her psychosocial and/or medical problem(s)?
4. What factors, genetic or environmental, may have contributed to patient's current problem(s)?

i. Plan

- i. List some specific suggestions regarding ways in which patient can improve current situation
 1. If patient is smoking, specify "enroll in a smoking cessation program."
 2. Individual/couple/family therapy?
 3. Support Group?
 4. If nutrition, housing, and/or finances, etc. are problematic, indicate community resources that may be helpful