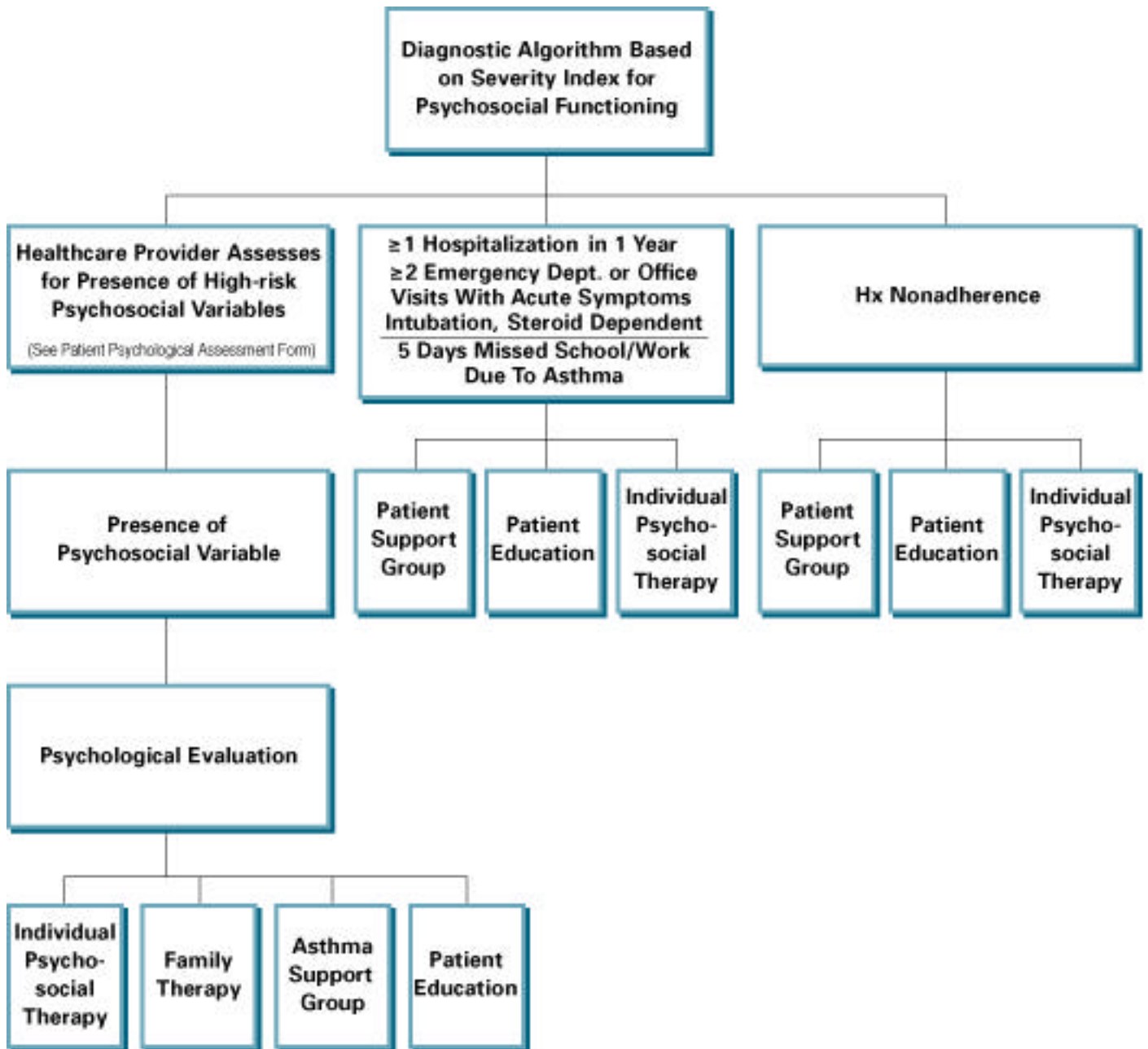


Psychosocial Intervention Care Path

Psychosocial Intervention Care Path Flow



Psychosocial Intervention Care Path

Patient Psychosocial Assessment Form (to be completed by Physician)

Name:

ID Number:

Emotional

What is the patient's emotional reaction to having asthma?

- No reaction at all Slight reaction Moderate reaction Significant reaction

Are emotions triggering asthma?

- Yes No

Is the patient currently experiencing emotional stress?

- Yes No

Are there current family stress factors, such as divorce, step-families, adoptions, marital discord, financial problems, school/work absenteeism?

- Yes No

How does the patient handle emotions?

- Very well Somewhat well Moderately well Not well at all

Physical

Is patient compliant with asthma medications?

- Yes No

Does patient have activities limited because of asthma?

- Yes No

Does patient participate in physical exercise?

- Yes No

What is the patient's activity level?

- Very active Somewhat active Moderately active Not active at all

Social/Family

Does patient have social interests or activities?

- Yes No

Does the asthma control the patient and/or family, or does the patient/family control the asthma?

- Former Latter

Has the patient ever had mental health counseling?

- Yes No

Does the patient have a support network?

- Yes No

If yes, of whom is it composed? _____

How does the patient interpret the support he or she receives from others in regard to his or her medication and peak flow monitoring, reminders, comments from others about watching out for triggers, etc.?

- Helpful Bothersome

Does the patient have regressive behavior?

- Yes No

What is the family interaction?

- Very involved Somewhat involved Moderately involved Not involved at all

Is there a family history of alcoholism, physical, psychological or sexual abuse?

- Yes No

What is the family structure? (check all that apply)

- Rigid Overprotective Enmeshed Permissive

Does the patient/family have qualities of high anxiety or low panic-fear?

- Yes No

Adult Psychosocial History

Name: _____

ID Number: _____

1. Please place the corresponding number on the line before each item which best describes how often YOU are feeling the following:

1. NOT AT ALL 2. ONCE A WEEK 3. 2-3 DAYS A WEEK 4. DAILY

- | | | | |
|----------------|----------------|------------------|-------------------|
| _____ Angry | _____ Confused | _____ Worried | _____ Depressed |
| _____ Isolated | _____ Happy | _____ Mad | _____ Embarrassed |
| _____ Sad | _____ Lonely | _____ Frustrated | _____ Scared |
| _____ Anxious | _____ Nervous | _____ Guilty | |

2. How have you been impacted by your respiratory symptoms with respect to the following?

1. NOT AT ALL 2. SLIGHTLY 3. MODERATELY 4. SIGNIFICANTLY

- | | |
|---|----------------------------------|
| _____ Relationship with significant other | _____ Family |
| _____ Social activities | _____ Relationships with friends |
| _____ Job/school performance | _____ Job/school absenteeism |
| _____ Housework | _____ Sexual relations |
| _____ Leisure activities | _____ Strenuous activities |
| _____ Sleep | _____ Mood |
| _____ Stress level | _____ Finances |

3. Family history (check all that apply):

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Verbal abuse |
| <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Suicide | |

4. Have you or any family members experienced any significant losses or changes in the past two years?

5. Have you ever received mental health counseling? Yes No

If yes, when? _____ With whom? _____

Reason for services: _____

Psychosocial Intervention Care Path

Pediatric Psychosocial History

Name: _____

ID Number: _____

Questionnaire for Parents or Guardians

Name: _____ Date: _____

Child's Name: _____ Child's Age: _____

1. Please place the corresponding number on the line before each item which best describes how often you notice your child feeling the following.

1. NOT AT ALL 2. SOME OF THE TIME 3. FREQUENTLY 4. ALL OF THE TIME

____ Happy	____ Mad	____ Confused
____ Sad	____ Frustrated	____ Depressed
____ Worried	____ Isolated	____ Other _____
____ Embarrassed	____ Scared	____ Other _____

2. Are there school stressors that affect your child and his/her symptoms?

Yes No

If yes, describe: _____

3. Does family-related stress affect your child?

Yes No

If yes, describe: _____

4. How do your child's symptoms affect the family?

5. In which of these areas do you have concerns related to your child?

<input type="checkbox"/> School issues	<input type="checkbox"/> Self-esteem	<input type="checkbox"/> Family relationships
<input type="checkbox"/> Anger	<input type="checkbox"/> Social activities	<input type="checkbox"/> Other
<input type="checkbox"/> Sibling issues	<input type="checkbox"/> Peer issues	

6. Family history (check all that apply):

<input type="checkbox"/> Mental illness	<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Sexual abuse
<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Emotional/verbal abuse	<input type="checkbox"/> Other
<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Suicide	

7. Has your child ever received psychological treatment or counseling? Yes No

If yes, when? _____ With whom? _____

Reason for services: _____

Psychosocial Intervention Care Path

Pediatric Psychosocial History

Name:

ID Number:

Questionnaire for Child

PLEASE FILL IN THE BLANKS:

1. What are your favorite activities?

1) _____

2) _____

2. Having asthma makes me feel: (check those feelings that apply)

Happy Embarrassed Scared Sad Mad Confused Lonely

Complete the following sentences:

3. I feel _____ about my family.

4. Sometimes I get mad about

5. Sometimes I feel sad because

6. I am the happiest when

7. Sometimes I feel scared when

Draw us a picture of how you feel today. (Please draw your picture on the back of this paper.)