Assessment of Client or Client System

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The ability to accurately assess a client system is crucial to quality social work practice. Assessment is essentially a “thinking process” where the social worker draws tentative conclusions based on the information gathered.

The best assessments are multidimensional in that the information obtained in the assessment process is obtained from multiple sources and incorporates the professional opinions of others. Once the information is gathered, organized, and studied; goals and objectives are developed with the client to address areas that are targeted for change and/or attention.

While the assessment process differs widely in various social work practice settings, there are several consistent components of most assessments and are as follows:

- Use “client” for the name of the person.
- Use non-identifying descriptors for family members, other persons, and professionals referred to in the assessment such as “client’s wife,” “client’s husband,” “client’s father,” “client’s partner,” “client’s 12-yr. old son,” “client’s psychiatrist,” “client’s case worker,” etc.
- Client’s Date of Birth
- Client’s relationship status
- Date of referral and/or case opening
- Time period covered in report

2. Presenting problem

- What circumstances resulted in the client system pursuing services from the agency or organization?
- What outcome of service provision does the client want?
- Is the client a voluntary or involuntary client? If the client is involuntary, then what are the objectives for client services that the referral source has identified?
3. Dates of Contact

- Include all dates of contact with client and collaterals during reporting period
- Include type of contact (in-person, phone, letter, text, e-mail, fax)
- Location of contact (Some agencies require the identification of where the service was provided as in “home” or “office.”)
- Length of contact (Some agencies require the length of each client or collateral contact, which is crucial information for billing)

4. Collection of background information

- Has the client system previously received services for the same or a similar issue? What was the outcome of the previous services?
- What past and present social history information that has been gathered is significant in understanding the client system? Significant information can include:
  - family of origin issues including loss and separation
  - past trauma experiences
  - mental health history of client or family
  - substance use history of client or family
  - biological processes
  - health or physical-related concerns of client or family
  - domestic violence history of client or family
  - parenting issues
  - economic concerns
  - housing issues
  - employment issues
  - cognitive level of functioning
  - legal issues
  - educational background
  - social support system
  - spiritual and religious beliefs
  - sexuality issues
  - sexual orientation
  - issues related to age
  - issues related to oppression and/or discrimination
  - current relationship dynamics with immediate and extended family
  - current neighborhood/community issues
5. **Bio-Psycho-Social Assessment Narrative**

Once the presenting problem is identified and background information is gathered from a variety of sources, a professional assessment should be formulated. This assessment should be strength-based (identify and build on client strengths) and should be clinical, or bio-psycho-social in nature, depending on the specific services provided and the credentials of the social worker. Writing a strength-based assessment may be harder than it sounds since you are often working with someone due to a presenting problem.

Some questions to get answers for:
- When were things going well in their lives and what was it about that period of time?
- What positive coping skills/activities do they utilize?
- What have they already been trying in order to address the concern?
- What are they hoping to achieve? What will life look like when things are better?

In many social work settings, the assessment often includes a DSM-V diagnosis. This process can only be done by a licensed clinical social worker or other qualified licensed professional.

6. **Recommendations**

Once the assessment is formulated and the areas of need are established, the social worker should make recommendations for the provision of services, when warranted.