

Assessment of Current Level of Functioning and Treatment Needs

Instructions on Administering the Assessment

The purpose of this assessment resource is to assist providers in matching specific treatment choices to the current needs of the child based on the child's level of functioning. The assessment provides a straightforward way for providers to gather information about a child's functioning in several life domains and information about the child's symptoms. The caregiver's responses to the questions help providers periodically assess that the types and amounts of services match the child's current level of functioning and treatment needs. In addition, the assessment helps providers focus their interventions at the child's specific treatment needs.

Providers should fill out the assessment through talking with the caregiver and eliciting answers to the questions. Usually this assessment should be conducted every four to six weeks but definitely should be used to gather information prior to every update of the child's Treatment Plan. This assessment should be filed with the child's chart.

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Client Name:

Date of Contact:

Start Time:

Are the services your child is currently receiving helping to meet his/her treatment goals?

Yes No

If no, what do you think would be helpful? Please be as specific as possible:

Family Functioning

Thinking back over the past week (or specify another time frame), how has your child generally been functioning in the home and with your family?

What have you noticed that has been going well?

What has been your biggest concern?

Dialogue with the caregiver, gather the following information and indicate the severity level of these questions by checking the appropriate box.

	No Problem	Minor Problem	Significant Problem
Is your child following instructions/requests?			
Is your child able to successfully complete household chores?			
Does he/she complete age appropriate daily hygiene?			
Does he/she follow an acceptable bedtime routine?			
How often has your child argued/talked back/yelled at family members?			
Has he/she displayed verbally aggressive behavior?			
What about physical aggression?			
How often does your child engage in daily activities with you/your family?			

How can your treatment team be helpful in improving your child's functioning in the family setting?

Caregiver's response to receiving additional attention in this area:

YES, additional services are needed NO additional services at this time

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School Functioning

Thinking back over the past week (or specify another time frame), how has your child generally been functioning at school? (Include alternate settings, i.e., preschool, daycare, summer programs)

Based on any reports from your child, his/her teacher(s) or your own observation, what have you noticed that has been going well?

What has been your biggest concern?

Dialogue with the caregiver, gather the following information and indicate the severity level of this question by checking the appropriate box.

	No Problem	Minor Problem	Significant Problem
How often has your child been attending school?			

If missing school, please tell me about the reason for the absences:

Dialogue with the caregiver, gather the following information and indicate the severity level of these questions by checking the appropriate box.

	No Problem	Minor Problem	Significant Problem
How often does he/she complete homework?			
Is your child displaying appropriate behavior at school?			
Do teachers report that he/she is focusing/concentrating on assignments?			
Do teachers report that he/she is able to follow directions?			
How often is your child being disciplined at school for misbehavior?			
Has your child received any in or out-of-school suspensions?			
How often does he/she complete homework?			
Is your child displaying appropriate behavior at school?			

How can your treatment team be helpful in improving your child's functioning in the school setting?

Caregiver's response to receiving additional attention in this area:

YES, additional services are needed NO services at this time

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Social / Community Functioning

Thinking back over the past week (or specify another time frame), how has your child generally been functioning in social and community settings?

What have you noticed that has been going well?

What has been your biggest concern?

Dialogue with the caregiver, gather the following information and indicate the severity level of these questions by checking the appropriate box.

	No Problem	Minor Problem	Significant Problem
How often does your child engage in activities with friends?			
How often do you approve of the friends your child chooses?			
Is your child involved in social/community groups?			
Does your child show respect for the property of others?			
How often does your child get into verbal conflicts with peers?			
How often does your child get into physical conflicts with peers?			
Has your child been involved in activities in the community that could get him/her into trouble?			

How can your treatment team be helpful in improving your child's functioning in the community setting?

Caregiver's response to receiving additional attention in this area:

YES, additional services are needed NO services at this time

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Symptoms

Over the past week (or specify time frame) how has your child been doing with the symptoms for which he/she is receiving treatment?

(If applicable) Is your child taking his/her medications as prescribed? Yes No
 If no, can you tell me what gets in the way?

What can we do to help with this issue?

Dialogue with the caregiver about whether or not your child is experiencing any of the following symptoms. Gather the information and indicate the severity level of these questions by checking the appropriate box.

	No Problem	Minor Problem	Significant Problem
Depression (sadness, feeling down)			
Anxiety (worry, fear)			
Sleep problems			
Appetite problems			
Irritability			
Anger			
Trouble paying attention or concentrating			
Hyperactivity			
Rapidly changing moods			
Acting shy or withdrawn			
Using alcohol or other drugs			
Self-injurious behavior – i.e.: cutting on self (If yes, contact a QMHP IMMEDIATELY!)			
Suicidal thoughts (If yes, contact a QMHP IMMEDIATELY!)			
Suicidal behavior (If yes, contact a QMHP IMMEDIATELY!)			
Other symptoms:			

Are there any changes you think need to be made to your child's treatment plan? Yes No
 If yes, please indicate what changes you'd like to see:

Is there anything we haven't talked about that you want the treatment team to know?

Name of provider completing this form:

Service Provided:

Stop time: