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|  | | | | | | | |  | | | | | | | | | File number : | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | |
| Last, first name: | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | |
|  | | | | | | | |
|  | | | | | |  | | Birth date : | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | |
|  | | | | | |  | | Mother’s last & first name : | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | |
|  | | | | | |  | | Father’s last & first name : | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | |
| **FAMILY & FRIEND’S NEEDS** | | | | | | | | | | | | | | | | | Telephone number : | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **INFORMATION ON THE INDIVIDUAL** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The person living with a mental health illness is : | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| My father | | | | | | | | | | | | My brother | | | | | | | | | | | | | My son | | | | | | | | | | My partner | | | | | | | | | | | | | | |
| My mother | | | | | | | | | | | | My sister | | | | | | | | | | | | | My daughter | | | | | | | | | | Other: | | | | | |  | | | | |  | | | |
| Age : | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| They live : | | | | | | | | | with me | | | | | | | | | | | | | | | In a residence | | | | | | | | | | In an apartment | | | | | | | | | | in a room | | | | | |
|  | | | | | | | | | other (specify) | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | |
|  | | | | | | | | | For how long? | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| How often do you see them? | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MEDICAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How long have they been having difficulties? (Approx. date?) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | |
| Do you know the diagnosis? | | | | | | | | | | | | | | No | | | | | | Yes (What is it?) | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | |
| Do they take medication? | | | | | | | | | | | | | | No | | | | | | Yes (Which?) | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| For what reason is, medication prescribed. | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
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| Do they accept treatment? | | | | | | | | | | | | | Always | | | | | | | | Most of the time | | | | | | | | | | | | | | | Sometimes | | | | | | | Never | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PORTRAIT OF SITUATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **For each of the following phrases, identify what has been the most difficult for you to live with & understand** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PHRASES** | | | | | | | | | | | | | | | | | | | | | | | **DEGREE OF DIFFICULTY** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | NOT DIFFICULT | | | | | | | | | | A LITTLE | | | | | AVERAGE | | | | VERY DIFFICULT | | | | | | | |
| Agitated or Inactive : | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | |  | | | |  | | | | | | | |
| Acts strange : | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | |  | | | |  | | | | | | | |
| Unusual hours for sleeping or activities: | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | |  | | | |  | | | | | | | |
| Insomnia or sleeps too much : | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | |  | | | |  | | | | | | | |
| Social withdrawal : | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | |  | | | |  | | | | | | | |
| Physically violent : | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | |  | | | |  | | | | | | | |
| Unacceptable behavior during meals : | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | |  | | | |  | | | | | | | |
| **FAMILY & FRIEND’S NEEDS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Name : | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | File number : | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
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| **PORTRAIT OF THE SITUATION (CONT.)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PHRASES** | | | | | | | | | | | | | | | **DEGREE OF DIFFICULTY** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | NOT DIFFICULT | | | | | | | | | | | | | | A LITTLE | | | | | | | AVERAGE | | | | | VERY DIFFICULT | | | | | | | |
| Alcohol /and or drug use : | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Inactive : | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Fears or false beliefs : | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Hallucinations : | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Accepts treatment : | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Odd or irrational statements : | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Frequent mood swings : | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Suicidal thoughts : | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Difficulty communicating : | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Neglects personal hygiene : | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Demands a lot: | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Verbal violence : | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Other: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Other: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
| Other: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | |
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| **FAMILY & FRIEND’S NEEDS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **WHAT WOULD YOU LIKE TO KNOW ABOUT TREATMENT?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Effects of medication | | | | | | | | | | | | | | | | | | | | | | | | | | Treatment | | | | | | | | | | | | | | | | | | | | | | |
| Illness | | | | | | | | | | | | | | | | | | | | | | | | | | Support groups | | | | | | | | | | | | | | | | | | | | | | |
| Support programs | | | | | | | | | | | | | | | | | | | | | | | | | | Warning signs of a relapse | | | | | | | | | | | | | | | | | | | | | | |
| Intervention tools | | | | | | | | | | | | | | | | | | | | | | | | | | Legal support | | | | | | | | | | | | | | | | | | | | | | |
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| **WHAT DO YOU FEEL?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Powerless | | | | | | | | | | | | | | | | | | | | | | | | | | | Shame | | | | | | | | | | | | | | | | | | | | | |
| Overwhelmed | | | | | | | | | | | | | | | | | | | | | | | | | | | Anger | | | | | | | | | | | | | | | | | | | | | |
| Guilty | | | | | | | | | | | | | | | | | | | | | | | | | | | Family conflict | | | | | | | | | | | | | | | | | | | | | |
| Fear | | | | | | | | | | | | | | | | | | | | | | | | | | | Insecure | | | | | | | | | | | | | | | | | | | | | |
| Isolation | | | | | | | | | | | | | | | | | | | | | | | | | | | Marginalised by those around me | | | | | | | | | | | | | | | | | | | | | |
| Judgement from others | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | |  | | | | |
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| **FAMILY & FRIEND’S NEEDS** | | | | | | | | |  | | |
| Name : | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | File number : | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | | | | | | | | |
| **FAMILY & FRIEND’S NEEDS (CONT.)** | | | | | | | | |
| **What are your needs & objectives?** | | | | | | | | | | | |
| Accept situation | | | | | | | | | | | |
| Express your needs to the person in difficulty | | | | | | | | | | | |
| Allow yourself leisure time | | | | | | | | | | | |
| Have emotional support | | | | | | | | | | | |
| Know the possibilities for growth & independence of person with mental health problem | | | | | | | | | | | |
| Able to express my limits | | | | | | | | | | | |
| Communicate effectively with the person | | | | | | | | | | | |
| Enlarge support network | | | | | | | | | | | |
| Understand what are realistic expectations to have towards the person | | | | | | | | | | | |
| Identify realistic expectations towards the person | | | | | | | | | | | |
| Other needs : | | | |  | | | | | | |  |
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| **PRIORITISE NEEDS** | | | | | | | | | | | |
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| Date: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Intervener’s signature : | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | |

Source: CSSS Saguenay-Lac-Saint-Jean (Translated by Jeffery Hale Community Services)