**NEEDS ASSESSMENT**

**SNAP**

**CDS Family & Behavioral Health Services**

**PARTICIPANT INFORMATION Date of Assessment:**

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| **Full Name:**  | **Participant #:**  |
| **A.K.A:** | **DOB:** | **Sex:** | **Age:** | **Race:** |
| **Address:**  |
| **School Attending:**  | **Grade:**  |

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| **Full Names:**  |
| **Address:**  |
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| **Home Phone:**  | **Cell Phones:**  |
| **Work Phone:**  | **Email:**  |
| **Place of Employment:**  |

**PARENT/GUARDIAN INFORMATION**

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| **Participant/Family Members Present for Interview:**  |

**PRESENTING PROBLEM:** (Why does the participant/parent/guardian want to be involved in

SNAP? Does the child have any anxiety, fears? Is his/her behavior the same across environments/people? What are his/her feelings like? Describe affect. How can you tell his/her affect? Able to enjoy him/herself? Able to communicate emotions?)

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**Willingness to participate in service (participant and parent/guardian):** Describe his/her communication style. How is he/she at communicating his/her needs? Express his/herself appropriately? Strengths? Does he/she take initiative to communicate his/her needs?

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**What does the participant/parent/guardian hope to gain from services?**

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**What are the participant’s strengths and interests?**

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**Describe family interaction:** What activities does the family participate in together? Does each parent get a break from this environment? Describe your parenting style/ other parents parenting style. Are parents consistent when dealing with inappropriate behaviors? Describe the relationship between siblings. Describe the communication style between family members.

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**REINFORCEMENT TRAP CYCLE:** Have parents explain this by describing cycle. Describe a

typical problem (e.g. routine) that you have with him or her. Problem---- Parent reacts----Child reacts---Parent reacts---- How long does it last? How does it end?

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**PSYCHIATRIC/COUNSELING HISTORY:** (hospitalizations, counseling, agency involvement,

diagnosis, current medications etc.)

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**EDUCATIONAL HISTORY:** (Academic, behavioral, truancy background, special program

involvement, grades, referrals, suspensions, etc.)

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**POTENTIAL FOR VIOLENCE/ABUSE:** (physical, mental, emotional, and sexual)Sense of withdrawal or isolation from other kids in school? Why withdrawn or isolated? Affected by this? How? Gets bullied at school? Or, bullies at school? Friends at school? What kind of friends? Good/bad choices? Ages of friends? Enjoy school? Describe communication between yourself and teachers? Regular contact? If no comfortable initiating contact?

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**LIST ALL FAMILY MEMBERS AND OTHERS LIVING IN THE HOME:**

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**LOCATION/INVOLVEMENT OF FAMILY/NON-FAMILY MEMBERS WHO DO NOT**

**LIVE IN THE HOME:** (Is there another parent/guardian who should be aware/involved in our service delivery? If yes, plans for notification.)

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**FAMILY HISTORY DEVELOPMENTAL ISSUES:** (includes milestones, deaths remarriages,

accidents, pregnancy/prenatal, substance abuse/birth problems developmental milestones) What was it like to bond with your new baby? What type of social supports did you have during and post pregnancy? How would you describe your confidence as a parent? Are/were there any significant caregivers in your life? How would you describe the bond between them and your child?

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**PARTICIPANT RESIDENTIAL HISTORY:** (with whom has the participant lived in the past, when and for how long?)

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**CHILDREN & FAMILY HISTORY OF ABUSE:** (previous or current abuse, neglect or

abandonment investigations; dependency involvement assistance received, etc.)

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**LEGAL HISTORY:** (previous or current arrests/charges, involvement with law enforcement etc.)

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**FINANCIAL HISTORY:** (does the family’s current financial situation relate to the present problem)

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**DRUGS/ALCOHOL HISTORY:** (both participant and family household members)

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**PEER RELATIONSHIPS:** (number and depth of relationships with friends, romantic/sexual relationships etc.)

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| **SUICIDE ASSESSMENT:**  | Yes or No  |
| 1. Have you ever attempted to kill yourself?  |   |
| 2. Are you thinking about killing yourself now?  |  |
| 3. Do you have a plan (specific method) to kill yourself?  |  |
| 4. Do you feel that life is not worth living or wish you were dead?  |  |
| 5. Have you recently been in a situation where you did not care whether you lived or died?  |  |
| 6. Have you felt continuously sad or hopeless?  |  |

**Explain any ‘yes’ responses:**

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**ASSESSMENT SUMMARY** (if applicable):

 [ ] Spoke with Licensed Mental Health Counselor; Completed Suicide Assessment; Created a plan.

[ ] No risk reported.

**MENTAL, PHYSICAL AND EMOTIONAL STATUS:** (appearance, mood affect, motor

activities/speech, flow and content of thought, memory/orientation, hallucinations/delusions, insights/judgment)

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**COUNSELOR’S IMPRESSIONS, COMMENTS AND INTERPRETIVE SUMMARY:** (this section is an overall summary, based on assessment data)

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Counselor Signature Title/Credential Date

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 Supervisor Signature Title/Credential Date