|  |  |  |  |
| --- | --- | --- | --- |
|  | **Client Profile** | File #: |  |
| Surname, name: |  |
|  |
|  |  | Date of birth: |  |
|  |  | Surname, name of mother: |  |
|  |  | Surname, name of father: |  |

|  |  |
| --- | --- |
| **1. LIVING ENVIRONMENT** |  |
| **In which type of housing do you live?** |
| [ ]  A room: |  |  | [ ] Family-type  | [ ]  Apartment | [ ]  Residence |
| [ ]  Other: |  |  |
| **What do you like about your living situation?**  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **What do you think could be improved?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **What have you done to try to improve these aspects?**  |
|  |  |  |
|  |  |  |
|  |  |  |
| **What else could be done to improve things?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Where would you like to be living one year from now? (life plan)** |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |

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| --- |
| **Client Profile** |
| Name: |  | File #: |
| **1. LIVING ENVIRONMENT (CONT.)** |
|  |  |
|  | **Type of residence** | **With whom** | **How long** | **Reason for leaving** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Home living activities (HLA)** |
| Are you currently able to: |
| Prepare simple meals? | [ ] Yes | [ ]  No | Examples: |  |
| Plan your meals? | [ ] Yes | [ ]  No | Examples: |  |
| Use the microwave? | [ ] Yes | [ ]  No | Examples: |  |
| Use the oven? | [ ] Yes | [ ]  No | Examples: |  |
| Do your grocery shopping? | [ ] Yes | [ ]  No | Examples: |  |
| Do your housework? | [ ] Yes | [ ]  No | Examples: |  |
| Do your laundry? | [ ] Yes | [ ]  No | Examples: |  |
| Make your bed? | [ ] Yes | [ ]  No | Examples: |  |
| Put away your clothes? | [ ] Yes | [ ]  No | Examples: |  |
| Throw out useless items? | [ ] Yes | [ ]  No | Examples: |  |
| Empty the trash?  | [ ] Yes | [ ]  No | Examples: |  |
| **Daily activities (ADL)** |
| Personal hygiene |
| In a week, how often do you:  |
| * Take a shower or bath?
 |   |
| * Brush your teeth?
 |  | * Use deodorant?
 |  |
| Do you sometimes need to be reminded to do these things?  | [ ]  Yes | [ ]  No |
| Do you sometimes need help with these activities? | [ ]  Yes | [ ]  No |
| Food and nutrition |  |  |
| Do you eat: |  |  |
|  | **Food** | **If so, how much, how often**  | **If not, why?** |
|  | Milk and dairy products |  |  |
|  | Meat and substitutes |  |  |
|  | Fruit and vegetables |  |  |
|  | Bread and cereals |  |  |
|  | Sweets and snacks |  |  |
|  | Soda, water, juice |  |  |
|  | Tea and coffee |  |  |

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| **Client Profile** |
| Name: |  | File#: |  |
| **1. LIVING ENVIRONMENT (CONT.)** |
| **Activities of daily living (ADL) (cont.)** |
| How many meals do you eat per day?  |  |
| Do you eat between meals? |  |
| How much do you weigh?  |  | kg |  | lbs |  |
| Have you lost or gained weight recently? |  |
| Are you satisfied with your weight? |  |
|  |  |  |
| **2. OCCUPATIONS** |
|  |  |
|  |  |
|  |  |
| Are you satisfied with these leisure activities and how after?  | [ ] Yes | [ ]  No |
| If not, what would it take to increase your level of satisfaction?  |
|  |  |
|  |  |
|  |  |
| Are you interested in any other leisure activities? If so, which ones?  |
|  |  |
|  |  |
|  |  |
| **EDUCATION** |
| What is the highest level of education you have completed?  |
|  |  |
| What are/were your areas of interest? Your strengths? What you enjoyed most?  |
|  |  |
|  |  |
| Would you like to go back to school?  | [ ]  Yes | [ ]  No |  |
| If so, what would you like to study? |  |  |
|  |  |
| **Client Profile** |
| Name: |  | File#: |  |
| **2. OCCUPATIONS (CONT.)** |  |
| **Employment or volunteer work** |
| Do you have or have you ever had a job?  | [ ] Yes | [ ]  No |
| If so, in which field? |  |  |
|  |  |
|  |  |
| Do you do or have you ever done volunteer work? |  [ ]  Yes |  [ ]  No |
| If so, in which field? |  |  |
|  |  |
|  |  |
| What are your interests and strengths in terms of employment or volunteer work?  |
|  |  |
|  |  |
| What type of job or volunteer work would you like to do? |
|  |  |
|  |  |
| **Time management** |
| Do you use an agenda?  | [ ]  Yes | [ ] No |
| A calendar? | [ ]  Yes | [ ] No |
| A memory aid? | [ ]  Yes | [ ] No |
| **Transportation** |
| What type(s) of transportation do you use? |
| [ ]  Walking | [ ]  Bus | [ ]  Car | [ ]  Bicycle | [ ]  Adapted transport | [ ]  Carpooling |
|  |  |
| **Services Used** |  |
| Which services do you use? |  |
| [ ]  Post office | [ ]  Library | [ ]  Hair salon |
| [ ]  Stores | [ ]  Cinema | [ ]  Bank or credit union |
| [ ]  Community Organizations | [ ]  Restaurants | [ ]  Other |
|   |

|  |
| --- |
| **Client Profile** |
| Name: |  | File#: |  |
| **3. Social network/friends/family/spirituality**  |  |
| **Marital Status** |
| [ ]  Single | [ ]  Common-Law | [ ]  Married | [ ]  Divorced |
| [ ]  Widowed |  |  |  |
| Since when : |
| Are you satisfied with this living situation? [ ]  Yes [ ]  No  |
| Why? |
|  |  |  |  |
|  |  |  |  |
| **Children** |  |  |  |
|

|  |  |  |
| --- | --- | --- |
| **Name** | **Age** | **Frequency of Contact** |
|  |  |  |
|  |  |  |
|  |  |  |

 |
| If the person has one or more children : |
| Do you pay or receive support? [ ]  Yes [ ]  No Type : |
| **Meaningful relationships** |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Frequency of contact** | **Relationship** | **Activities** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

 |
| Are you satisfied with your relationships? [ ]  Yes [ ]  No |
| Why? |
|  |
|  |
| **Spirituality** |
| Do you have spiritual beliefs or fundamental values that have meaning for you (love, peace, generosity, etc.)? |
|  |
|  |
| How do you express your spirituality? What activities do you practice in connection with your beliefs? |
|  |
|  |
|  |
|  |
|  |
| **Client Profile** |
| Name: |  | File#: |  |
| **3. Social network/friends/family/spirituality (CONT.)** |  |
| Are you interested in developing the spiritual side of your life? |
|  |
|  |
|  |
| Have you done anything in the past to improve your spiritual life? |
|  |
|  |
|  |
|  |
| **4. PHYSICAL HEALTH**  |
| Do you have physical health problems? [ ]  Yes [ ]  No If yes, which ones? |
|  |
|  |
|  |
| What kind of problems does this cause you? |
|  |
|  |
|  |
| Do you take medications for your physical health problems? [ ]  Yes [ ]  No |
|  |
|  |
| **Medical Check-ups** |
| Do you get medical check-ups, either for prevention or for a specific physical health problem |
| (General practitioner, dentist, optician/ophthalmologist, etc.)? |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Function** | **Since when** | **Frequency** | **Reasons** |
|  |  |  |  |  |
|  |  |  |  |  |
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| --- |
| **Client Profile** |
| Name: : |  | File#: |  |
| **4. PHYSICAL HEALTH (CONT.)** |  |
| **Sleep** |
| What are your sleep habits (time you rise and go to bed)?  |  |
|  |  |
| How would you rate the quality of your sleep? [ ]  Excellent [ ]  Good [ ]  Fair [ ]  Poor |
| **If your sleep quality is unsatisfactory**: |
| A. How would you describe your sleep problem? |
| [ ]  Difficulty falling asleep  | [ ]  Difficulty waking up | [ ]  Wake up often | [ ]  Nightmares |
| Other: |  |
| B. What are the consequences of poor sleep for you? |  |
|  |  |
| **SEXUALITY** |
| Are you satisfied with your current sex life? [ ]  Yes [ ]  No |
| Why? |  |
|  |  |
| Do you have sexual concerns? [ ]  No [ ]  Yes |
|  |  |
| Do you use birth control? [ ]  Yes [ ]  No |  |
|  |  |  |  |
|  |
| **5. MENTAL HEALTH** |
| **Mental health awareness** |
| Do you consider yourself to be in good mental health? | [ ]  Yes | [ ]  No |  |
| Why? |  |
|  |  |
| Have you been diagnosed with a mental health illness? [ ]  Yes [ ]  No (Which one?) |  |
| What do you know about this illness?  |  |
|  |  |
| What do you think of this diagnosis (agree or disagree)?  |  |
|  |  |
| How did you feel when you were given this diagnosis? |
|  |

|  |
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| **Client Profile** |
| Name: |  | File#: |  |
| **5. MENTAL HEALTH (CONT.)** |  |
| **Onset of the illness** |
| When and how did the illness start? |
|  |  |
|  |  |
| What did you think when the first symptoms started?  |
|  |  |
|  |  |
| How did your friends, family, etc. react?  |
|  |  |
|  |  |
|  |  |
| What was your life like before this diagnosis? |
|  |  |
|  |  |
|  |  |
| **Current situation** |
| What symptoms do you experience in your day-to-day life?  |
|  |  |
|  |  |
|  |  |
| Are there times when the symptoms are worse?  |
|  |  |
|  |  |
|  |  |
| When do you feel at your best? |
|  |  |
|  |  |
| Do you feel you have a certain amount of control over your symptoms? If so, how?  |
|  |  |
|  |  |
| **Client Profile** |
| Name: |  | File#: |  |
| **5. MENTAL HEALTH(CONT.)** |  |
| Do you believe recovery is possible despite your current symptoms? |
| [ ]  Yes [ ]  No |
| What obstacles are standing in the way of a possible recovery for you (personal or outside obstacles)?  |
|  |
|  |
| What would help you recover (e.g., social network, support from an intervener, etc.)?  |
|  |  |
| What were your plans for the future before the illness started?  |
|  |  |
|  |  |
| Now, what is your plan for the future or your dreams for the next few years?  |
|  |  |
|  |  |
| Do you know anyone who could help you reach your goal one day (friend, family, intervener, etc.)?  |
|  [ ]  Yes [ ]  No |  |
| **Depression and suicidal thoughts** |
| ➊ In the last few months, have you felt down, depressed or hopeless? [ ]  Yes [ ]  No |
| ➋ In the last few months, have you often experienced a loss of interest or enjoyment in accomplishing regular, day-to-day activities?  |
|  [ ]  Yes [ ]  No |
| 🡺 If answer is “Yes” to either of these two questions, complete the suicide emergency evaluation grid.  |
|  |
| **Dangerousness and violence** |
| Do you have a history of violence? [ ]  No [ ]  Yes*🡺* If answer is “Yes” or if answer is “No” but intervener knows of history of violence, complete the form “Safety Mesures-Adult Mental Health” |
|  |
| **Use of mental health and community resources**  |
| Current follow-up(s): psychiatrist, nurse, social worker, community organizations or other  |
|  |
|  | **Name** | **Function** | **Since when** | **Frequency** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **Client Profile** |
| Name: |  | File#: |  |
| **5. MENTAL HEALTH (CONT.)** |
| Are you satisfied with the services available to you?  | [ ]  Yes | [ ]  No |
| Why? |  |
|  |  |
|  |  |
| What type of service would you like to receive?  |  |
|  |  |
|  |  |
| **History of hospitalizations** |
| Have you ever been hospitalized in connection with your mental health issues? [ ]  Yes [ ]  No  |
| If so : |
| How many times?  |  | Was it against your will?  |  |
| Why? |  |
|  |  |
|  |  |
|  |  |
| How do you feel about these hospital stays? |  |
|  |  |
|  |  |
|  |  |
| **Medication (Mental Health)**  🡺 Complete the pharmacological profile  |
| Do you know the name, dose and frequency of your medications?  | [ ]  Yes | [ ]  No |
| What are you taking this medication for?  |  |
|  |  |
|  |  |
| How do you feel about taking this medication (for or against)?  |  |
|  |  |
|  |  |
| Do you sometimes fail to take your prescription medication? [ ]  Yes [ ]  No If so, why? (e.g. forget, take more medications than prescribed, etc.)? |
|  |
|  |
| **Client Profile** |
| Name: |  | File#: |  |
| **5. MENTAL HEALTH(CONT.)** |
| Does your medication cause side effects? [ ]  Yes [ ]  No If so, what are they? |
|  |  |
|  |  |
| At which pharmacy do you get your medications? (name and address)  |  |
|  |  |
| Are you the one who gets your prescriptions refilled? [ ] Yes [ ]  No If not, who does it for you?  |
|  |  |
|  |  |
|  |  |  |  |
|  |
| **6. DRUGS/ALCOHOL** |  |
| **TOBACCO** |
| Have you tried to reduce your tobacco use? | [ ]  Yes | [ ]  No |  |
| **ALCOHOL & DRUGS** |
| ➊ Have you tried to drink less or do less drugs? [ ]  Yes [ ]  No |
| ➋ Has your use of alcohol or drugs caused a reaction from your family or friends? [ ]  Yes [ ]  No |
| ➌ Have you ever said to yourself that you drink too much alcohol or do too many drugs? [ ]  Yes [ ]  No |
| ➍ The next day after you have consumed a lot, have you found that your body was reacting? |
|  (Ex: need to drink in the morning, shaky hands)? [ ]  Yes [ ]  No |
| **GAMBLING** |
| ➊ During the past year, have you hidden or tried to hide your gambling habits from  |
|  others (ex: family members)? [ ]  Yes [ ]  No |
| ➋ During the past year, while you were gambling, have you played longer than you had planned  |
|  at the start? [ ]  Yes [ ]  No |
|  |  |  |  |
| **7. cognitive functions** |  |
| Do you often forget appointments, familiar phone numbers or other common things? [ ] Yes[ ] No |
| Do you sometimes find it difficult to stay focused on a task or conversation?  |
| [ ]  Yes [ ]  No |
| Do you sometimes get so lost in your own thoughts that you are unable to listen to what people are saying to you?  |
| [ ]  Yes [ ]  No |
| Do you sometimes go to a room and then forget why you wanted to go there? [ ]  Yes [ ]  No |
| **🡺 If possible, double check these facts with a family member, friend, roommate, etc. after obtaining the person’s consent** |
| **Client Profile** |
| Name: |  | File#: |  |
| **7. COGNITIVE FUNCTIONS (CONT.)** |
|  |  |
|  | **Observations of the intervener** |  |
|  | Person has difficulty: |  |
|  | ➊ Staying focused during meetings, following the conversation, maintaining eye contact, etc.  |  |
|  | [ ]  Yes [ ]  No |  |
|  | ➋ Remembering what was said in past meetings or tends to repeat the same stories many times.  |  |
|  | [ ]  Yes [ ]  No |  |
|  | ➌ Using an agenda, telephone, calendar, telling time, etc. [ ]  Yes [ ]  No |  |
|  | ➍ Knowing what day, month or year it is [ ]  Yes [ ]  No |  |
|  |  |  |
|  |  |  |
|  | If you checked “yes” to some of the statements and observed that the person experiences these difficulties most of the time, refer him or her to the appropriate neuropsychological resource in your catchment area.  |  |
|  |  |  |  |  |
| **8. FINANCES AND LEGAL MATTERS** |
| **Income** |  |
|  |  |
|  | **Source of Income** | **Amount** | **Contact Person** |  |
|  | [ ]  Employment assistance (welfare)Serious employment constraint [ ]  Yes [ ]  No |  |  |  |
|  | [ ]  Employment insurance (UI) |  |  |  |
|  | [ ]  Quebec pension plan  |  |  |  |
|  | [ ]  Salary insurance |  |  |  |
|  | [ ]  Other source: |  |  |  |
| How much do you spend, on average, every month on: |  |  |
| Rent: |  |  |  |
| Electricity: |  | Phone: |  | Cable: |
| Food: |  | Medications: |  | Laundry: |  |
| Transportation: |  | Life insurance: |  | Home insurance: |  |
| Other expenses: |  |
| Can you meet your needs with your current income? [ ]  Yes [ ]  NoIf not, why? |
|  |  |
| **Budget management** |
| Do you manage your budget on your own? [ ]  Yes [ ]  No: 🔾 Private curatorship 🔾 Public curatorship 🔾 Tutorship |
| Do you have a bank or credit union account? [ ]  Yes [ ]  No |
| Which methods of payment do you use? [ ]  ATM card (bank card) [ ]  Cheques [ ]  Bank teller [ ]  Credit card |
| **Client Profile** |
| Name: |  | File#: |  |
| **8. FINANCES AND LEGAL MATTERS (CONT.)** |
| Do you find it difficult to handle money and check your change?  |
| [ ]  Yes | [ ]  No | \*If so, under what circumstances? |  |
| Do you keep your money and valuables in a safe place? [ ]  Yes [ ]  No |  |
| Do you owe money? [ ]  Yes [ ]  No |  |
| **Legal matters** |  |
|  | **Legal Matters** | **Comments** |  |
|  | [ ]  Administration by a third party |  |  |
|  | [ ]  Youth centre |  |  |
|  | [ ]  Private curator or tutor |  |  |
|  | [ ]  Public curator |  |  |
|  | [ ]  Probation |  |  |
|  | [ ]  Tribunal administrative du Québec (TAQ) |  |  |
|  | [ ]  TAQ with delegation of authority |  |  |
|  | [ ]  Incident/Accident Report |  |  |
|  | [ ]  Société d’assurance automobile du Québec |  |  |
|  | [ ]  Justice[ ]  Alimony[ ]  Succession[ ]  Wanted notice[ ]  Criminal complaints[ ]  Other (explain)  |  |  |
|  | [ ]  Treatment order | Effective from: to  |  |
|  | [ ]  Housing order | Effective from: to  |  |
|  |  |  |  |  |
| **Atmosphere and dates of meetings:** |
|  |  |  |
|  |  |  |
|  |  |  |
| **Comments from intervener:** |  |
|  |  |  |
|  |  |  |
| Date: |  | Signature of intervener:  |  |  |

Source: CSSS Saguenay et le Lac-Saint-Jean Translated by Jeffery Hale Community Services

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