



Provincial Youth Addictions Treatment Centre Grand Falls Windsor

CAREGIVER ASSESSMENT FORM

Thank you for taking the time to complete this assessment form. The information you provide will assist us in better understanding your family's current situation and concerns. Research has shown that meaningful caregiver involvement in the treatment process leads to the best possible outcomes for youth and their families. As part of our treatment process, your involvement and ongoing communication with our clinicians is recommended by our clinical team.

Please read and complete this document in full. If you require more space, please feel free to write on the back of the pages. Should you not understand a question, simply indicate 'DK' (don't know) beside the relevant question. Likewise, if you feel a particular question does not apply to your circumstances, simply indicate 'N/A' (not applicable). In situations whereby more than one caregiver is involved (e.g. mother and father are co-parenting), we ask that each caregiver complete his/her own form separately. Upon completion, please be sure to sign and date this form.

Lastly, we ask that you take the time to thoroughly read the 'Caregiver Information Package' that has been provided to you. This package contains important information pertaining to our program.

Youth Information	
First Name:	Last Name:
Date of Birth:	CRMS #:
MCP#:	Nickname:
Current Address:	

Caregiver Name: _____

Caregiver Address: (Street): _____

(City/Town/Province): _____

(Postal Code): _____

Caregiver's Relationship to Youth: _____

Primary Telephone Number: _____

Okay to contact you at this number? Yes No

Other telephone number: _____

Okay to contact you at this number? Yes No

Occupation/ Place of Work: _____

Emergency Contact Person: _____

Contact Telephone Number(s): _____

Please list all individuals considered siblings by the youth, including biological, adopted, step, foster, etc.

Name	Age	Gender	Relationship	Lives with

Please indicate **other persons living in the home**, not including the youth's siblings.

Name	Age	Gender	Relationship

Why do you think your youth is being referred for treatment?

Is youth aware of this referral?

Yes No

To your knowledge, how long has youth been abusing:

Drugs: _____ Alcohol: _____

What substance(s) do you suspect your youth is currently using or used in the recent past?

Substance	Frequency	Amount	Duration

Does your family believe the youth recognizes that he/she has a problem? If yes, please explain.

Are you currently engaged with Community Addictions Services? Yes No

If yes, please provide name and contact information of counselor:

Name: _____

Address: _____

Telephone Number: _____

Have **you** ever been involved in counseling (previously or presently), including marital, family, or individual? Yes No

If yes, please list: when, location, type of counseling, and outcomes reached.

Do any other family members **currently** abuse drugs and/or alcohol? Yes No

If yes, who: _____

Have any other family members abused drugs/alcohol **in the past**? Yes No

If yes, who: _____

Would you and/or your family be willing to come to the treatment centre to take part in family counseling/education sessions or participate via teleconference when needed?

What strategies or supports does your family use to cope with stressful events?

How would you describe the way in which your family communicates with each other?

What are some of the rules/limit settings used within your home?

What activities does your family do together?

What are your youth's strengths?

What special qualities or talents does your youth have (present/past) that you are particularly proud?

Does your youth have any special needs; learning disabilities; behavioral problems?

Please describe both positive and/or negative family events that have occurred in the past year.

How can you support your youth's recovery at this time?

Other comments (anything else you feel needs to be shared):

Caregiver's Signature: _____ Date: _____