CASIG(C)

Consumer ID		Consumer Name
Service Date	Staff ID	Staff Name

HOUSING/ LIVING GOALS

Ask the client: *One year from now, what would you like your living arrangements to be?*

_____

What do you currently have (e.g.: assets, past experience or resources) that could help you meet that (these) goal(s)?

_____

What type of help (e.g.: support or services) would you need to meet that (these) goal(s)?

_____

FINANCIAL/ VOCATIONAL GOALS

Ask the client: *Would you like to improve your financial/money situation in the next year?* ☐**Yes** ☐**No**
If yes, ask: *How might you improve it?*

_____

If not mentioned in the previous question, ask: *Do you wish to work or attend either a school or a training program in the coming year?* ☐**Yes** ☐**No**
If yes, *What are your vocational or educational goals?*

_____

What do you currently have (e.g.: assets, past experience or resources) that could help you meet that (these) goal(s)?

_____

What type of help (e.g.: support or services) would you need to meet that(these) goal(s)?

_____

RELATIONSHIP GOALS

Ask the client: *Would you like to improve your relationships with people (in general), friends, family or intimate partner (couple) in the next year?* ☐**Yes** ☐**No**
If yes, *How could you improve this (or these) relationship(s)?*

_____

What do you currently have (e.g.: assets, past experience or resources) that could help you meet that (these) goal(s)?

_____

What type of help (e.g.: support or services) would you need to meet that (these) goal(s)?

_____

SPIRITUAL/ RELIGIOUS GOALS

Ask the client: *Do you have spiritual or religious goals?* ☐**Yes** ☐**No**
If yes, *What are they?*

_____

What do you currently have (e.g.: assets, past experience or resources) that could help you meet that (these) goal(s)?

_____

What type of help (e.g.: support or services) would you need to meet that(these) goal(s)?

_____

HEALTH GOALS

Ask the client: *Would you like to improve your physical health in the next year?* ☐**Yes** ☐**No**
If yes, *What are your physical health goals (e.g.: work on physical problems, stop using street drugs, exercise more) in the coming year?*

_____

What do you currently have (e.g.: assets, past experience or resources) that could help you meet that (these) goal(s)?

_____

What type of help (e.g.: support or services) would you need to meet that (these) goal(s)?

_____

Ask the client: *Would you like to improve your mental health in the next year?* ☐**Yes** ☐**No**
If yes, *What are your mental health goals (e.g.: symptom management, taking meds without help) in the coming year?*

_____

What do you currently have (e.g.: assets, past experience or resources) that could help you meet that (these) goal(s)

_____

What type of help (e.g.: support or services) would you need to meet that (these) goal(s)?

_____

LIFESTYLE SUPPORTS

Ask the client: *Besides the support and services you already mentioned before, what other help would you need to improve your quality of life?*

_____

Go back to the first page to see where the client lives. Ask the client: *You mentioned living at _____, since when?* If less than 3 months, *Where did you live before that? _____ The following questions pertain to the last 3 months, so since you have been living at _____.*

MONEY MANAGEMENT

Ask the client: *Since you have been living at _____, in the last 3 months, did you*

	Yes	No	No ans.
1. Receive income/assistance payments directly (not through a payee).....	☐	☐	☐
2. Pay by cash or check for your food and rent?.....	☐	☐	☐
3. Keep your money in a safe place?.....	☐	☐	☐
4. Keep most of your money and resist giving it away?.....	☐	☐	☐
5. Budget your money and avoid making foolish purchases so you wouldn't run out?.....	☐	☐	☐
6. Have a valid picture ID you could use to cash checks?.....	☐	☐	☐

Goal: *Do you want to make it a personal goal to improve how you manage your money?* ☐**Yes** ☐**No**
How much help or support would you need to improve how you manage your money ?

☐**1**----------☐**2**----------☐**3**----------☐**4**
None **A little** **A fair amount** **A lot**

Comments or observations:

HEALTH MANAGEMENT

Ask the client: *Since you have been living at _____, in the last 3 months, did you*

	Yes	No	No ans.
1. Make most of your own appointments with your doctor, case manager, etc?.....	☐	☐	☐
2. Keep these appointments without reminders from someone?.....	☐	☐	☐
3. Buy your own medication (not necessarily with your money)?.....	☐	☐	☐
4. Administer your own medication?.....	☐	☐	☐
5. Care for yourself when you had a mild illness (e.g.: flu)?.....	☐	☐	☐
6.Have in your possession your birth certificate or benefits card (needed to verify identity for certain benefits)?.....	☐	☐	☐

Goal: *Do you want to make it a personal goal to improve how you manage your health?* ☐**Yes** ☐**No**
How much help or support would you need to improve how you manage your health?

☐**1**----------☐**2**----------☐**3**----------☐**4**
None **A little** **A fair amount** **A lot**

Comments or observations:

NUTRITION

Ask the client: *Since you have been living at _____, in the last 3 months, did you*

	Yes	No	No ans.
1. Plan your meals with a healthy balance of foods?	☐	☐	☐
2. Prepare simple meal like sandwiches or tv dinners?.....	☐	☐	☐
3. Use a microwave to prepare meals?.....	☐	☐	☐

	Yes	No	No ans.
4. Use a stove or oven to prepare meals?.....	☐	☐	☐
5. Clean and store dishes and silverware at least once every 3 days?.....	☐	☐	☐
6. Buy your own groceries?.....	☐	☐	☐
7. Stay well-stocked enough so you wouldn't run out of food?.....	☐	☐	☐

Goal: *Do you want to make it a personal goal to improve your nutrition and food preparation?*

☐**Yes** ☐**No**

How much help or support would you need to improve your nutrition and food preparation?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Comments or observations:

_____

VOCATIONAL

Ask questions in order, as soon as the client answers "**yes**", check "**yes**" for the remaining questions and skip to 7a.

Ask the client: *Since you have been living at _____, in the last 3 months, did you*

	Yes	No	No ans.
1. Have a paid job in the community (full-time or part-time)?.....	☐	☐	☐
2. Have a supported employment job?.....	☐	☐	☐
3. Have a sheltered workshop or activity?	☐	☐	☐
4. Use services of the Department of Voc Rehab to find a job or get training?	☐	☐	☐
5. Participate or graduate from a job training program?..... **If yes, which program? _____**	☐	☐	☐
6. Have an interview for a job/ work activity/ workshop?.....	☐	☐	☐
7a. Do you feel comfortable working 4 hours without a break?.....	☐	☐	☐
7b. (**If 7a is "no", ask the question, otherwise check "yes**) Do you feel comfortable working 1 hour without break?.....	☐	☐	☐
8. Do you have a social security card with you or do you know the number?.....	☐	☐	☐

Goal: *Do you want to make it a personal goal to obtain or maintain a job (part-time or full time)?*

☐**Yes** ☐**No**

How much help or support would you need to obtain or maintain a job?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Comments or observations:

_____

TRANSPORTATION

Ask the client: *Since you have been living at _____, in the last 3 months, did you*

	Yes	No	No ans.
1. Have a valid driver's license?	☐	☐	☐
2. Drive a car (yours or someone else's)?	☐	☐	☐
3. Use public transportation alone (bus or train)?	☐	☐	☐

Goal: *Do you want to make it a personal goal to improve your getting around by using the public, or your own, transportation system?* ☐**Yes** ☐**No**

How much help or support would you need to improve your getting around by using the public, or your own, transportation system?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Comments or observations:

_____

FRIENDS

Ask the client: *Since you have been living at _____, in the last 3 months, did you*

	Yes	No	No ans.
1. Have friends? If yes, who and how many? _____	☐	☐	☐
2. Spend time talking to your friends?	☐	☐	☐
3. Do things together with your friends?	☐	☐	☐
4a. Have daily contacts with your friends?	☐	☐	☐
4b. (**If 4a is "no", ask the question, otherwise check "yes**") Have weekly contacts with your friends?	☐	☐	☐
5. Make one (or more) new friend(s)?	☐	☐	☐

Goal: *Do you want to make it a personal goal to improve your friendships or to make new ones?* ☐**Yes** ☐**No**

How much help or support would you need to improve your friendships or to make new ones?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Comments or observations:

_____

LEISURE

Ask the client: *Since you have been living at _____, in the last 3 months, did you*

	Yes	No	No ans.
1. Spend time on a hobby? If yes, which one(s)?_____	☐	☐	☐
2. Do a physical activity or sport?	☐	☐	☐

	Yes	No	No ans.
3. Play a table game, computer, or other games?.....	☐	☐	☐
4. Go to a movie, play, sporting event or shopping mall by yourself?.....	☐	☐	☐
5. Go to a movie, play, sporting event or shopping mall with friends?.....	☐	☐	☐
6. Read a book, magazine or newspaper?.....	☐	☐	☐
7. Write a letter or e-mail to a friend or realtive?.....	☐	☐	☐
8. Listen to music, watch tv or surf the net?.....	☐	☐	☐
9. Do an artistic activity (e.g.: writing, playing music, painting, etc)?.....	☐	☐	☐

Goal: *Do you want to make it a personal goal to improve your leisure activities?* ☐**Yes** ☐**No**
How much help or support would you need to improve your leisure activities ?

☐**1**----------☐**2**----------☐**3**----------☐**4**
None **A little** **A fair amount** **A lot**

Comments or observations:

_____

PERSONAL HYGIENE

If the physical appearance of the client is appropriate (not disheveled), check "**yes**"to all, otherwise ask the client*:*

Without reminders or assistance, did you...	Yes	No	No ans.
1. Take a shower or bath at least 3 times in the last week.....	☐	☐	☐
2. Brush your teeth everyday for the past week?.....	☐	☐	☐
3. Put on clean clothes at least 3 times in the last week?.....	☐	☐	☐
4. Shave at least once in the last 2 days **(check "yes" if a woman or man with a well-groomed beard)**	☐	☐	☐
5. Brush or comb your hair everyday in the last week (**check "yes" if bald**)?.....	☐	☐	☐
6. Put on deodorant everyday for the past week?.....	☐	☐	☐

Goal: *Do you want to make it a personal goal to improve your personal hygiene?* ☐**Yes** ☐**No**
How much help or support would you need to improve your personal hygiene ?

☐**1**----------☐**2**----------☐**3**----------☐**4**
None **A little** **A fair amount** **A lot**

Comments or observations:

_____

CARE OF PERSONAL POSSESSIONS

Ask the client: *Since you have been living at* _____*, in the last 3 months, without reminders or assistance, did you...*

	Yes	No	No ans.
1. Wash your clothes at least once in the past 2 weeks?.....	☐	☐	☐

	Yes	No	No ans.
2. Clean your room or apartment at least once in the past week?.....	☐	☐	☐
3. Make your bed at least once in the past 3 days?.....	☐	☐	☐
4. Put away your clothes at least once in the last three days?.....	☐	☐	☐
5. Discard unwanted items and empty your trash at least once in the past week?.....	☐	☐	☐

Goal: *Do you want to make it a personal goal to improve how you care for your personal possessions?* ☐**Yes** ☐**No**

How much help or support would you need to improve how you care for your personal possessions ?

☐**1----------**☐**2----------**☐**3----------**☐**4**

None **A little** **A fair amount** **A lot**

Comments or observations:

_____

MEDICATION PRACTICES

Ask the client the following questions:

	Yes	No	No ans.
1. If your physician prescribes medication for you, do you take it as prescribed?.....	☐	☐	☐
2. For the last 3 months, have you usually taken your medication as prescribed?.....	☐	☐	☐
3. Do you think that medication helps you?.....	☐	☐	☐
4. Is medication an important part of your treatment?.....	☐	☐	☐
5. Do you need to continue to take medication once you feel better?.....	☐	☐	☐
6. What medication(s) do you take?_____ (**"yes" if correct**)	☐	☐	☐
7. How are your meds supposed to help you? _____ (**"yes" if correct**).	☐	☐	☐
8. Do you feel good about your current medications and their dosages?.....	☐	☐	☐

Goal: *Do you want to make it a personal goal to learn more about your medications?* ☐**Yes** ☐**No**

How much help or support would you need to learn more about your medications ?

☐**1----------**☐**2----------**☐**3----------**☐**4**

None **A little** **A fair amount** **A lot**

Do you want to make it a personal goal to take care of your own medications?☐**Yes** ☐**No**

How much help or support would you need to take care of your own medications ?

☐**1----------**☐**2----------**☐**3----------**☐**4**

None **A little** **A fair amount** **A lot**

Comments or observations:

_____

SIDE EFFECTS

Ask the client: *Does your current medication cause problems like:*

Effects	Yes	No	No ans.	Effects	Yes	No	No ans.
1. Thirsty	☐	☐	☐	10. Tremors/ shaking	☐	☐	☐
2. Nervous, jittery	☐	☐	☐	11. Nausea/ vomiting	☐	☐	☐
3. Blurred vision	☐	☐	☐	12. (Men) impotence	☐	☐	☐
4. Constipation	☐	☐	☐	13. Dry mouth	☐	☐	☐
5. Drooling	☐	☐	☐	14. Dizziness	☐	☐	☐
6. Headaches	☐	☐	☐	15. Jaw movements	☐	☐	☐
7. Tired, sluggish	☐	☐	☐	16. Weight gain or loss	☐	☐	☐
8. Rigid muscles	☐	☐	☐	17. Sunburn	☐	☐	☐
9. Diarrhea	☐	☐	☐	18. Appetite changes	☐	☐	☐

Goal*: Do you want to make it a personal goal to diminish those side-effects?* ☐**Yes** ☐**No**

Comments or observations:

_____

RIGHTS

Say to the client*: I would like to find out how much you know about your rights,*
Do you have the right to...

	Yes	No	No ans.
1. Refuse to take medication that your physician has prescribed for you?.....	☐	☐	☐
2. Refuse to participate in activities that are part of your treatment?.....	☐	☐	☐
3. Have information about you kept confidential?.....	☐	☐	☐
4. Review your treatment plan and change the services you receive?.....	☐	☐	☐
5. See a Consumer Advocate to complain about poor treatment or services?.....	☐	☐	☐
6. Set goals for your treatment?.....	☐	☐	☐
7. Are you on Conservatorship?.....	☐	☐	☐
8. Have you ever complained to the Consumer Advocate?..... How did it turn out?_____	☐	☐	☐

Goal: *Do you want to make it a personal goal to learn more about your rights?* ☐**Yes** ☐**No**
How much help or support would you need to learn more about your rights?

☐**1**----------☐**2**----------☐**3**----------☐**4**
None **A little** **A fair amount** **A lot**

Comments or observations:

_____

COGNITIVE

Ask the client: *Right now or in the past 3 months, did you*

	Yes	No	No ans.
1. Have trouble remembering things you had learned or things you had to do?.....	☐	☐	☐

	Yes	No	No ans.
2. Have trouble concentrating on a specific task for more than a few minutes?.....	☐	☐	☐
3. Have trouble making decisions, not knowing how to evaluate your choices?.....	☐	☐	☐
4. Find it hard to find solutions to a problem when confronted to one?.....	☐	☐	☐
5. Often lose or misplace objects because you were absent-minded?.....	☐	☐	☐
6. Find it hard to use the things taught to you as part of your treatment in different areas of your everyday life?.....	☐	☐	☐

Goal: *Do you want to make it a personal goal to improve your memory, attention or thinking abilities?* ☐**Yes** ☐**No**

How much help or support would you need to improve your memory, attention or thinking abilities?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Comments or observations:

_____

QUALITY OF LIFE

Say to the client: *I would like to know how you feel about your life and living conditions. How do you feel about:*

	Poor	Fair	Good	Excellent	Comments (continue on back)
1.The money you have	☐	☐	☐	☐	_____
2. The fun you have	☐	☐	☐	☐	_____
3. Your personal belongings (safety)..	☐	☐	☐	☐	_____
4. Your personal safety	☐	☐	☐	☐	_____
5. Your health	☐	☐	☐	☐	_____
6. Your family	☐	☐	☐	☐	_____
7. Your friends	☐	☐	☐	☐	_____
8. Your housing	☐	☐	☐	☐	_____
9. Your abilities	☐	☐	☐	☐	_____
10. Your life in general	☐	☐	☐	☐	_____

Goal: *What would you like to change in your life, if anything?* _____

How much help or support would you need to meet that goal ?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Comments or observations:

_____

QUALITY OF TREATMENT

Say to the client: *I would like to know how you feel about your treatment. How do you feel about:*

	Poor	Fair	Good	Excellent	Comments (continue on back)

1. Your psychiatrist's skills.....	☐	☐	☐	☐	____
2. His/her courtesy	☐	☐	☐	☐	____
3. His/her availability	☐	☐	☐	☐	____
4. His/her listening to you and your concerns	☐	☐	☐	☐	____
5. His/her explanation of treatment	☐	☐	☐	☐	____
6. The staff's skills.....	☐	☐	☐	☐	____
7. Their courtesy.....	☐	☐	☐	☐	____
8. Their availability	☐	☐	☐	☐	____
9. Their listening to you and your concerns	☐	☐	☐	☐	____
10. Their explanation of treatment	☐	☐	☐	☐	____
11. Your treatment in general	☐	☐	☐	☐	____

Goal: *What would you like to change in your treatment, if anything?* ____
How much help or support would you need to meet that goal ?

☐1----------☐2----------☐3----------☐4
None A little A fair amount A lot

Comments or observations:

____

SYMPTOMS

For each question, as soon as a statement is answered **"yes"**, check **"yes"** for the question and go to the Goal.

Ask the client: *Now or anytime in the past 3 months...*

		Yes	No	No ans.
1.	Did you feel very fearful, worried, nervous or anxious?	☐	☐	☐
	Do you find it difficult to concentrate on doing things because you are so worried or anxious?	☐	☐	☐
	Did your nervousness interfere with your thinking and ability to do your usual activities like eating, sleeping, or working?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to learn to manage these symptoms?* ☐**Yes** ☐**No**

Now or anytime in the past 3 months...

		Yes	No	No ans.
2.	Do you feel very sad, hopeless or depressed?	☐	☐	☐
	Did this interfere with your thinking and your doing your usual activities like eating, sleeping, or working?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to learn to manage these symptoms?* ☐**Yes** ☐**No**

Now or anytime in the past 3 months...

		Yes	No	No ans.
3.	Do you feel so hopeless that you think about hurting yourself?	☐	☐	☐
	Are things so bad that you often think about ending your life?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to learn to manage these symptoms?* ☐**Yes** ☐**No**

Now or anytime in the past 3 months...

		Yes	No	No ans.
4.	Do you feel unusually good, "high", or elated for no reason?	☐	☐	☐
	Do your thoughts race through your mind?	☐	☐	☐
	Do you need less sleep or speak faster than usual?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to learn to manage these symptoms?* ☐**Yes** ☐**No**

Now or anytime in the past 3 months...

		Yes	No	No ans.
5.	Have you seen references to yourself on TV or in the newspaper?	☐	☐	☐
	Have things or events had a special meaning or a personal significance to you that is not recognized by others?	☐	☐	☐
	Have you felt that people are out to get you?	☐	☐	☐
	Has someone put thoughts into your head?	☐	☐	☐
	Have you had delusions or thought disorders?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to learn to manage these symptoms?* ☐**Yes** ☐**No**

Now or anytime in the past 3 months...

		Yes	No	No ans.
6.	Have you heard sounds, seen things, or smelled things that no one else has?	☐	☐	☐
	If yes, what?_____			
	Did you see anything unusual like a ghost or a spirit?	☐	☐	☐
	Did you hear someone talking to you but that person was not there?	☐	☐	☐
	Did this occur only when you were going to sleep?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to learn to manage these symptoms?* ☐**Yes** ☐**No**

Now or anytime in the past 3 months...

		Yes	No	No ans.
7.	Can you tell when your psychological problems are about to become worse or more intense?	☐	☐	☐
	Are there certain changes in how you're feeling or thinking that warn you there will be a change in your symptoms?	☐	☐	☐
	Are there warnings that your symptoms may become more intense and interfere with your ability to do your usual activities?	☐	☐	☐
	If yes, what are these signs_____			

Goal: If yes, *Do you want to make it a personal goal to learn to recognize and use these signs in order to prevent your symptoms from getting worse?* ☐**Yes** ☐**No**

Comments or observations:

_____

COMMUNITY BEHAVIORS

Ask the client: *Right now or in the past 3 months...*

	Yes	No	No ans.

1. Did you use street drugs? ..... ☐ ☐ ☐

Goal: If yes, *Do you want to make it a personal goal to quit using street drugs?* ☐**Yes** ☐**No**

How much help or support would you need to quit using street drugs ?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Right now or in the past 3 months...

	Yes	No	No ans.
2. Did you drink enough alcohol to get drunk at least once a month?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to quit or control your drinking?* ☐**Yes** ☐**No**

How much help or support would you need to quit or control your drinking ?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Right now or in the past 3 months...

	Yes	No	No ans.
3. Did you hurt someone by hitting, scratching, kicking, or other acts of violence?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to control your anger and violent outbursts?* ☐**Yes** ☐**No**

How much help or support would you need to control your anger and violent outbursts?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Right now or in the past 3 months...

	Yes	No	No ans.
4. Did you yell, threaten, insult or otherwise verbally assault someone?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to control your anger and verbal aggressiveness?* ☐**Yes** ☐**No**

How much help or support would you need to control your anger and verbal aggressiveness?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Right now or in the past 3 months...

	Yes	No	No ans.
5. Did you hurt yourself intentionally or even attempt to kill yourself?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to stop wanting to hurt yourself?* ☐**Yes** ☐**No**

How much help or support would you need to stop wanting to hurt?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Right now or in the past 3 months...

	Yes	No	No ans.
6. Did you engage in an illegal sexual activity that violated the rights of others?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to stop engaging in these behaviors?* ☐**Yes** ☐**No**

How much help or support would you need to stop engaging in these behaviors?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Right now or in the past 3 months...

Yes No No ans.

7. Did you smoke cigarettes (or other) in a hazardous way such as in bed)? ... ☐ ☐ ☐

Goal: If yes, *Do you want to make it a personal goal to smoke safely?* ☐**Yes** ☐**No**

How much help or support would you need to smoke safely?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Right now or in the past 3 months...

	Yes	No	No ans.
8. Did you steal other's property like money, cigarettes or clothes?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to stop stealing?* ☐**Yes** ☐**No**

How much help or support would you need to stop stealing?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Right now or in the past 3 months...

	Yes	No	No ans.
9. Did you damage or destroy other's property?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to stop such behaviors?* ☐**Yes** ☐**No**

How much help or support would you need to stop such behaviors ?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Right now or in the past 3 months...

	Yes	No	No ans.
10. Did you go AWOL from your residence or treatment program?	☐	☐	☐

Goal: If yes, *Do you want to make it a personal goal to stop running away?* ☐**Yes** ☐**No**

How much help or support would you need to stop running away?

☐**1**----------☐**2**----------☐**3**----------☐**4**

None **A little** **A fair amount** **A lot**

Comments or observations:

General comments, observations, and suggestions: