

SERVICE PROVIDER MONTHLY TREATMENT & PROGRESS SUMMARY Child and Adolescent Mental Health Division (CAMHD)

Instructions: Please complete and electronically submit this form to CAMHD by the 5th working day of each month (summarizing the time period of 1st to the last day of the previous month). The information will be used in service review, monitoring, planning and coordination in accordance with CAMHD policies and standards. Mahalo!

Client Name:	CR #:	DOB:
Month/Year of Services:	Eligibility Status:	Level of Care (one per form):
Axis I Primary Diagnosis:	Axis I Secondary Diagnosis:	Axis I Tertiary Diagnosis:
Axis II Primary Diagnosis:	Axis II Secondary Diagnosis:	

Service Format (circle all that apply):

Individual Group Parent Family Teacher Other: _____

Service Setting (circle all that apply):

Home School Community Out of Home Clinic/Office Other: _____

Service Dates:																
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Targets Addressed This Month (number up to 10):

	Activity Involvement		Community Involvement		Hyperactivity		Positive Peer Interaction		Shyness
	Academic Achievement		Contentment, Enjoyment, Happiness		Learning Disorder, Underachievement		Phobia/Fears		Sleep Disturbance
	Adaptive Behavior/Living Skills		Depressed Mood		Low Self-Esteem		Positive Thinking/Attitude		Social Skills
	Adjustment to Change		Eating, Feeding Problems		Mania		Pregnancy Education/Adjustment		Speech and Language Problems
	Aggression		Empathy		Medical Regimen Adherence		Psychosis		Substance Use
	Anger		Enuresis, Encopresis		Occupational Functioning/Stress		Runaway		Suicidality
	Anxiety		Fire Setting		Oppositional/Non-Compliant Behavior		School Involvement		Traumatic Stress
	Assertiveness		Gender Identity Problems		Peer Involvement		School Refusal/Truancy		Treatment Engagement
	Attention Problems		Grief		Peer/Sibling Conflict		Self-Control		Willful Misconduct, Delinquency
	Avoidance		Health Management		Personal Hygiene		Self-Injurious Behavior		Other:
	Cognitive-Intellectual Functioning		Housing/Living Situation		Positive Family Functioning		Sexual Misconduct		Other:

CR # _____ (please repeat the number here)

Progress Ratings This Month (check appropriate rating for any target numbers endorsed as targets):

#	Deterioration < 0%	No Significant Changes 0%-10%	Minimal Improvement 11%-30%	Some Improvement 31%-50%	Moderate Improvement 51%-70%	Significant Improvement 71%-90%	Complete Improvement 91%-100%	Date (If Complete)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Intervention Strategies Used This Month (check all that apply):

Activity Scheduling	Emotional Processing	Line of Sight Supervision	Personal Safety Skills	Stimulus or Antecedent Control
Assertiveness Training	Exposure	Maintenance or Relapse Prevention	Physical Exercise	Supportive Listening
Attending	Eye Movement, Tapping	Marital Therapy	Play Therapy	Tangible Rewards
Behavioral Contracting	Family Engagement	Medication/ Pharmacotherapy	Problem Solving	Therapist Praise/Rewards
Biofeedback, Neurofeedback	Family Therapy	Mentoring	Psychoeducation, Child	Thought Field Therapy
Care Coordination	Free Association	Milieu Therapy	Psychoeducation, Parent	Time Out
Catharsis	Functional Analysis	Mindfulness	Relationship or Rapport Building	Twelve-Step Program
Cognitive	Goal Setting	Modeling	Relaxation	Other:
Commands	Guided Imagery	Motivational Interviewing	Response Cost	Other:
Communication Skills	Hypnosis	Natural and Logical Consequences	Response Prevention	Other:
Crisis Management	Ignoring/Differential Reinforcement of Other Behavior	Parent Coping	Self-Monitoring	
Cultural Training	Individual Therapy for Caregiver	Parent/Teacher Monitoring	Self-Reward/ Self-Praise	
Discrete Trial Training	Insight Building	Parent/Teacher Praise	Skill Building	
Educational Support	Interpretation	Peer Pairing	Social Skills Training	

CR # _____ (please repeat the number here)

Psychiatric Medications (List All)	Total Daily Dose	Dose Schedule	Check if Change	Description of Change
_____	_____	_____	<input type="checkbox"/>	_____
_____	_____	_____	<input type="checkbox"/>	_____
_____	_____	_____	<input type="checkbox"/>	_____
_____	_____	_____	<input type="checkbox"/>	_____
_____	_____	_____	<input type="checkbox"/>	_____

Projected Discharge Date: _____ Check if Discharged During Current Month

IF YOUTH WAS DISCHARGED THIS MONTH, PLEASE COMPLETE ITEMS A & B:

A. Discharge Living Situation (check one):

- Home Foster Home Group Care Residential Treatment
 Institution/Hospital Jail/Correctional Facility Homeless/Shelter Other: _____

B. Reason(s) for Discharge (check all that apply):

- Success/Goals Met Insufficient Progress Family Relocation
 Runaway/Elopement Refuse/Withdraw Eligibility Change Other: _____

Outcome Measures: Optional. If you have any of the following data, please report the most recent scores:

CAFAS (8 Scales): (1-School:) (2-Home:) (3-Community:) (4-Behavior Toward Others:)	Date:		
(5-Moods/Emotions:) (6-Self-Harm:) (7-Substance:) (8-Thinking:) (Total:)			
CASII/CALOCUS (Total):	CASII/CALOCUS (Level of Care):	Date:	
CBCL (Total Problems T):	CBCL (Internalizing T):	CBCL (Externalizing T):	Date:
YSR (Total Problems T):	YSR (Internalizing T):	YSR (Externalizing T):	Date:
TRF (Total Problems T):	TRF (Internalizing T):	TRF (Externalizing T):	Date:
Arrested During Month? (Y/N):	School attendance (% of days):		

Comments/Suggestions (attach additional sheets if necessary):

Provider Agency & Island: _____	Clinician Name and ID#: _____
Provider Supervisor Signature: _____	Clinician Signature: _____
Submitted to CAMHD (date): _____	Care Coordinator: _____