Family Needs Assessment Survey (Relative)

Thank you for taking the time to complete this 5-10 minute survey. We want to address your needs and concerns related to your loved one’s mental health diagnosis, treatment, communication and/or support needs. We will make every effort to address your concerns and provide you with resources.

Your Name: ______________________________  Today’s date: ______________________________
Loved One’s Name: ________________________  Your relationship to this person: ____________
Name and type of program your loved one receives services: ________________________________
_________________________________________________________________________________
_________________________________________________________________________________

A. Have you had contact (telephone or face-to-face) with anyone from your loved one’s treatment team in the past year? YES/NO (circle answer, describe below, and on back if needed)
_________________________________________________________________________________
_________________________________________________________________________________

B. Please describe how you felt about this contact. (Use back if needed)
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

C. Were your concerns and needs addressed adequately?
_________________________________________________________________________________

D. How long has your loved one been diagnosed with mental health problems? ____________
If you know you’re your loved one’s diagnosis, please list here________________________________
_________________________________________________________________________________
_________________________________________________________________________________

E. Below is a list of topics on which people may want assistance. Please circle up to five topics with which you would like to have more assistance, and then put a star next to the topic most important to you right now:

I WOULD LIKE

1) Information about my loved one’s diagnosis

2) Information about the causes and genetics of mental illness

3) To learn the signs/symptoms of my loved one’s illness

4) To learn more about the treatment my loved one is receiving

5) To know what support is available to help my loved one obtain Independence (i.e., work and vocational rehabilitation)

6) To know what medication my loved one is taking and to learn about benefits & possible side effects from the medication

7) To learn the effect that substances (drugs/alcohol) may have on my loved one’s mental health condition.
8) Information about what to expect for my loved one’s future

9) To learn better ways in which I can communicate with my loved one

10) To talk about how my loved one’s illness affects the whole family

11) To talk about my feelings toward my loved one

12) To talk about how to cope with my feelings

13) To talk to other family members about mental illness

14) Information about how to cope with symptoms of my loved one’s illness

15) To learn more about the availability of family support groups

16) To know how I can be directly involved in my loved one’s treatment

17) To learn about social outlets and supports for people with mental illness

18) To know when there are changes in my loved one’s condition

19) To know what steps to take if/when my loved one begins to relapse or symptoms get worse

20) To learn ways I can contribute to help other families coping with similar challenges in their families

21) To learn more about healthy lifestyles (e.g., nutrition, exercise)

22) To learn ways to educate others that may not be informed about mental health illnesses

23) To learn more about any benefits to which my loved one is entitled

24) To learn more about housing options for my loved one

25) To learn more about school options for my loved one

26) To learn more about how to help my loved one manage physical health conditions (e.g., diabetes, high blood pressure)

F. We aim to address any/all concerns and questions you have. Please list other needs or concerns you may have in the space provided and on the back, if needed.