

FAMILY CARE PLAN: INTERNALIZING TEMPLATE

Medical Record No. or Stamp

FAMILY CARE PLAN: Internalizing Template (Copy for family and other team members.)

Child's full name: _____ Date of birth: _____

Date originated: _____ Dates revised: _____

STRENGTHS

PROBLEM AREAS/DIAGNOSES

Problem areas/diagnoses	Diagnostic code	Date/status*	Date/status*	Date/status*
1.				
2.				
3.				

*N = new; W = worsening; O = unchanged; + = improving; R = remission.

THERAPEUTIC GOALS

Date initiated:	Specifics	Date/status*	Date/status*	Date/status*
<input type="checkbox"/> Youth/family goals				
<input type="checkbox"/> Improve safety	<input type="checkbox"/> Suicidal thoughts/behavior <input type="checkbox"/> Self-injurious behavior <input type="checkbox"/> Property destruction <input type="checkbox"/> Verbal aggression <input type="checkbox"/> Physical aggression <input type="checkbox"/> Bullying/bullied <input type="checkbox"/> Environment <input type="checkbox"/> Weapon/meds <input type="checkbox"/> Emergency plan <input type="checkbox"/> Other:			
<input type="checkbox"/> Improve lifestyle	<input type="checkbox"/> Diet <input type="checkbox"/> Sleep <input type="checkbox"/> Physical activity <input type="checkbox"/> Screen time <input type="checkbox"/> Outdoor activities <input type="checkbox"/> Social contact			
<input type="checkbox"/> Improve functioning	<input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Community <input type="checkbox"/> Peers <input type="checkbox"/> Learning evaluation <input type="checkbox"/> Other:			
<input type="checkbox"/> Reduce symptoms	<input type="checkbox"/> Developmental <input type="checkbox"/> Neurologic <input type="checkbox"/> Somatic <input type="checkbox"/> Mood <input type="checkbox"/> Risk behaviors <input type="checkbox"/> Anxiety <input type="checkbox"/> Disruptive behavior <input type="checkbox"/> Other:			
<input type="checkbox"/> Improve self-management skills/resilience	<input type="checkbox"/> Self-awareness <input type="checkbox"/> Self-soothing skills <input type="checkbox"/> Self-regulation <input type="checkbox"/> Other:			
<input type="checkbox"/> Improve communication	<input type="checkbox"/> Address conflict within family <input type="checkbox"/> Partner with school <input type="checkbox"/> Address grief/loss issues within parent/family <input type="checkbox"/> Other:			
<input type="checkbox"/> Improve understanding of condition/illness/treatment	<input type="checkbox"/> Rec book(s): Rapee et al (anxiety) <input type="checkbox"/> Rec Web: www.aboutourkids.org www.nctsnct.net/org/nctsnct/nav.do?pid=hom_main <input type="checkbox"/> Rec Web: www.nami.org <input type="checkbox"/> Brochure: Tips for Parenting the Anxious Child <input type="checkbox"/> Brochure: Teen Suicide, Mood Disorder, and Depression <input type="checkbox"/> Brochure: Your Family's Mental Health: 10 Ways to Improve Mood Naturally <input type="checkbox"/> Guidelines for Special Time <input type="checkbox"/> Other:			
<input type="checkbox"/> Prevent/reduce substance use	<input type="checkbox"/> Reinforce abstinence or reduction <input type="checkbox"/> Monitor <input type="checkbox"/> Brief intervention <input type="checkbox"/> Referral <input type="checkbox"/> Remove alcohol/other substances from home			
<input type="checkbox"/> Other:	<input type="checkbox"/> Decrease environmental stressors <input type="checkbox"/> Avoid reliving trauma <input type="checkbox"/> Avoid triggers of low mood <input type="checkbox"/> Gradually increase exposure to feared objects/events/persons (anxiety) <input type="checkbox"/> Reward brave/positive behavior <input type="checkbox"/> Increase parent's confidence in addressing child's problems <input type="checkbox"/> Increase parent's confidence in addressing own problems <input type="checkbox"/> Seek care from other source(s) <input type="checkbox"/> Other:			

*N = new; + = progress toward goal; 0 = no progress toward goal.

TYPES OF THERAPY AND SUPPORT					
Provider/organization/ family member	Name/phone	Type of care or role*	Date/status*	Date/status*	Date/status*
Parents		<input type="checkbox"/> Rewards for good/brave behavior <input type="checkbox"/> Special time <input type="checkbox"/> Decrease stressors <input type="checkbox"/> Natural mental health improvements <input type="checkbox"/> Remove weapons/meds <input type="checkbox"/> Other: _____			
Child care/school personnel		<input type="checkbox"/> Decrease stressors <input type="checkbox"/> Communicate with parents/child <input type="checkbox"/> Other: _____			
Patient		<input type="checkbox"/> Lifestyle _____ <input type="checkbox"/> Reading _____ <input type="checkbox"/> Self-management _____ <input type="checkbox"/> Exposure plan (fears) <input type="checkbox"/> Relaxation <input type="checkbox"/> Journal <input type="checkbox"/> Positive thinking <input type="checkbox"/> Problem-solving <input type="checkbox"/> Practice skills <input type="checkbox"/> Behavioral activation <input type="checkbox"/> Other: _____			
Mental health professional(s)		<input type="checkbox"/> Psychosocial therapy _____ <input type="checkbox"/> Med <input type="checkbox"/> Other: _____			
Primary care clinician		<input type="checkbox"/> Care coordination <input type="checkbox"/> Med <input type="checkbox"/> Facilitate referral(s) <input type="checkbox"/> Other: _____			
Agency/other					

*I = individual therapy; F = family therapy; G = group therapy; SA = substance abuse therapy; MHCM = mental health case management;
 M = mentor program; P = peer support; Med = medication; CC = care coordination through primary care; O = other (specify).

MEDICATIONS			
Name	Purpose	Side effects to monitor	Dates dose changed

☐ See Psychopharmacologic Medication Flow Sheet. ☐ Labs: _____
 Dates: _____

FOLLOW-UP	
Next appointment	
Emergency contact	

Clinician's signature/date: _____

Initials/date reviewed: _____

Parent/guardian signature/date: _____

Initials/date reviewed: _____

Youth's signature/date: _____

Initials/date reviewed: _____

