Print Form

Circles of Care
Basic Child Monthly Progress Report

Complete one of these reports, monthly, for each Basic child you have in placement with you. Turn in this form every month to Circles of Care. Please be specific and give some detail. If additional space is necessary attach additional sheets of paper.

Child Name:_____ For the month of: _____ to _____

(I) Address the following areas. A person should be able to read this report and get an idea of what it is like to live with this child, how they function, what their needs are and how they compare to other children of the same age as well as progress they make or lack of progress.

(A) Basic Needs, Medical & Dental (Discuss supervision level, medical complaints, concerns or appointments. Supervision issues, or basic needs concerns.) If no needs or no concerns check appropriate box.

- ☐ No medical concerns, child remains healthy
- ☐ No hospitalizations
- ☐ No medical appointments this month

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(B) Educational. (How child is doing in school this month, both with grades and behaviorally**)** If no needs or no concerns check appropriate boxes. (Provide copies of any educational information such as report cards, notes, and any Special Education documents as applicable.)

- ☐ Child is doing well academically
- ☐ Child doing well behaviorally
- ☐ No concerns or calls from school personnel

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(C) Developmental/Life Skills and Emotional. (How does child do on day to day responsibilities such as assigned chores, skill abilities, emotional status and therapy information**)** If no needs or no concerns check appropriate box.

- ☐ Child is developmentally on target
- ☐ Child is compliant with chores
- ☐ Child is doing well with personnel hygiene
- ☐ Child remains emotionally stable

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NUTRITION, HYGIENE & GROOMING

APPETITE		*HYGIENE*		*DAILY GROOMING ASSISTANCE NEEDS*			
	Good		Good		Independent		Some Assistance in the following:
	Under-eating		Fair		Fully Dependent		
	Refusing to eat		Improving				Bathing
	Over-eating		Poor				Toileting
	Over-drinking		Refusing				Hair
VOIDING PROBLEMS							Nails
	Encopresis		Average Times Weekly				Teeth Care
	Enuresis		Average Times Weekly				Dressing

SUPPORTIVE SERVICES: (if applicable)

Dates of ECI services:	
Dates of Occupational Therapy:	
Dates of Speech Therapy:	
Dates of Physical Therapy:	
Special Equipment, Supplies/Nursing/Attendant Care	
Comments about progress:	

INDEPENDENT LIVING SKILLS: (for youth 16+ years old)

Describe the independent living skills practiced this month (i.e., manage bank account, applying for college, budgeting, grocery shopping, meal planning, laundry, housing searches, employment searches):
IF EMPLOYED PROVIDE THE FOLLOWING INFORMATION:

Place of Employment:	
Average Hours Worked:	
Comments:	

(D) Recreational/Social. (What types of activities did child due during the month such as free play time, family activities like movies or church or out to eat. How did child do while participating during activity**)**

(E) Behavioral. (Any checked items must be described in detail below).

1		Physical Restraint	20		Stares blankly
2		Physically Assaults peers/adults	21		Sulks, pouts, whines constantly
3		Breaks rules/ oppositional	22		Acts fearful, or anxiously
4		Threatens people	23		Sleep problems
5		Is cruel, bullying, or mean to others	24		Is under active, slow moving, or lack energy
6		Talks about killing self or others	25		Lies, and or cheats
7		Deliberately harms self or others	26		Screams
8		Does not feel guilty after misbehaving	27		Cries more or less than usual for age
9		Sexually acting out	28		Demands attention
10		Steals	29		Cant sit still, is restless or hyperactive
11		Exhibits strange or bizarre behavior	30		Difficulty concerning, easily distracted
12		Is sad, unhappy, or depressed-after Any kind of communication with biological	31		Worries excessively, preoccupied, with minor annoyances
13		Eating problems	32		Swears, uses foul language, makes obscene gestures
14		Hallucinates(visual, audio, or other)	33		Has temper tantrums, volatile out bursts
15		Wets self during the day and wets the bed	34		Impulsive, acts without thinking
16		Has bowl movement outside the toilet	35		Exhibits sudden mood swings
17		Withdraws/ isolates	36		Refused medication
18		Does not get along with other children	37		Other:
19		Expresses feelings of worthless. Inferiority	38		Other:

Any restraints occur this month: ☐ Yes ☐ No. **If yes,** a separate Incident and Restraint Documentation Form must be completed and should be reported to Circles of Care immediately.
Incident Report(s) completed and turned in this month. ☐ Yes ☐ No

(II) **Visitation/Involvement with Family.** Contact/visits with who and how, how did child do after any approved visits. Did they have any contact with anyone that you don't think is allowed as per CPS or the courts or contact that you are concerned about.

☐ Child had no visits this month

(III) **Monthly Fire or Emergency Procedures reviewed with children.**
Review should be done with children in your care once a month**.**
Dates you review this month: _____

Please note any significant concerns or issues regarding this review**.**

(IV) ADDITION OF CLOTHING AND PERSONAL ITEMS (of substantial value) DURING MONTH

CLOTHING ITEMS	*# OF ITEMS*	*PERSONAL ITEMS*	**CHILD'S SIGNATURE*

***Child's signature to verify addition of clothing and/or personal items when age and developmentally able.**

(V) Special Concerns/other issues/misc.

☐ No special concerns or other issues

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Completed by:_____

Care Provider- Foster/Adopt parent Date

Reviewed by:_____

Circles of Care staff/case manager Date