Worksheets

Intervention Chart

Date:
Client:

Goal	Plan

Information Gathering Guide

Domain	Information Cues	Comments
Symptoms	• Cognitive symptoms • Physical symptoms • Diagnosis • Pre-injury diagnosis/co-morbidity	
Emotional Health	• Isolation • Loneliness • Have they accessed support? • Psychology or counseling initiated • Feelings of depression and loss	
Personal Care	• Pre & post-injury routine • Medications • Finding items • Length of time to complete task	
Housekeeping	• Pre & post-injury routine • Who does what? • Quality of work • Type of equipment • Length of time to complete task	
Lawn Care	• Pre & post-injury routine • Safety • Type of equipment • Length of time to complete task	

Domain	Information Cues	Comments
Transportation	• Pre & post-injury routine • Safety • Bus, taxi, or independent driver • Status of driver's license	
Finances	• Pre & post-injury routine • Is the client on a budget?	
Shopping	• Pre & post-injury routine • Transportation • Financial issues • Shopping lists • Spending habits	
Child Care	• Pre & post-injury routine • Safety • Information about children (ages, schedules, routines)	
Volunteer	• Pre & post-injury routine • Currently participating • Modified or gradual return to participation possible	

Domain	Information Cues	Comments
Work	• Pre & post-injury routine • Is a Job Site Analysis required? • Currently working • Modified or gradual return to work possible • Financially motivated • Physician's recommendations	
Leisure	• Pre & post-injury routine • What can they do now? • Loss of interest	
Social	• Pre & post-injury routine • Behavioural incidents • Conversational skills	
Spirituality	• Pre & post-routine	
School Activities, Continuing Education	• Pre & post-routine • At which stage was the client in the process?	
Future Life Goals		
Other		

Cognitive Symptom Checklist - Part 1

Please indicate in the column if the symptom is experienced or observed.
S = Survivor
C = Caregiver/Family Member
SP = Service Provider

Symptom	S	C	SP	Comments
I run around all day trying to get things done. At the end of the day, nothing is finished.				
I re-read paragraphs over and over but cannot retain the information.				
If I try to monitor or do two things at once, I get overwhelmed and frazzled (i.e., talk on the phone and feed the cat). I have to stop doing one thing.				
I drive to the grocery store but, once I get there, I have no idea what I was going to buy.				
I think that people take advantage of me because of my injury.				
I do not always remember if I've used soap or washed my hair.				
I lose track of time.				
I spend way too long doing one job and run out of time to get anything else done				
I do not remember conversations with people.				
When I get tired, I make comments or tell jokes that people seem to be surprised by.				

Symptom	S	C	SP	Comments
I feel overwhelmed when someone asks me to do something.				
There's a lot to remember and do - it is only natural to forget some things.				
Sometimes, I will look for something for a long time before realizing that it is in front of me.				
I cannot seem to meet deadlines.				
Bright lights bother me.				
I get confused when I cook. I cannot always finish the meal.				
I have a headache a lot of the time.				
I cannot be bothered to clean. Someone else will do it.				
I cannot see as well as I used to.				
Walls and furniture sometimes seem to move.				
There are so many things I should do, but I do not know where to start, so I avoid everything.				
I do not always know what's important.				
When getting dressed, I get overwhelmed with the choices and cannot decide what to wear.				
When I cannot remember the next step, I get stuck. I just stop.				

Symptom	S	C	SP	Comments
I work too fast and make mistakes.				
It takes me a long time to get things done. I am always running behind.				
It is hard to apply strategies (e.g., resting) when I am in the middle of a busy day.				
I do not recognize my mistakes until they have been pointed out to me.				

Cognitive Symptom Checklist – Part 2

Please indicate in the column if the symptom is experienced or observed.

S = Survivor
C = Caregiver/Family Member
SP = Service Provider

Symptom	S	C	SP	Comments
I forget appointments.				
When I am overwhelmed, I do not know what to do, so I just stop doing everything.				
I agree to do things before I think about how long they will take or if I can fit them in to my day.				
I forget to write things down.				
When I talk to more than one person, I am usually quiet and try not to say the wrong thing.				
Sometimes, I will make a mistake and blame someone else for it.				
When I am tired, I get confused easily and I cannot remember things.				
People tell me I can be rude, but I do not realize I am doing it.				
I burn pots on the stove.				
When I go to the store, I get overwhelmed. I forget to buy what I need and get tired quickly.				
Sometimes, I will walk into a room and realize that I left the iron/ stove/ kettle/coffee maker on.				
Recipes confuse me. I often miss a step.				

Symptom	S	C	SP	Comments
Once I've started a conversation, I get a little lost and do not know what to talk about or how to end it.				
I do not always realize when people are busy, and are hinting for me to stop talking or leave.				
I always seem to end up arriving at places at the wrong time, the wrong day, too late, or too early.				
I have the best of intentions, but have a very hard time following through with strategies.				
I forget to pay the bills.				
I do not always realize when I've hurt someone's feelings.				
I feel like my brain gets tired easily.				
I do not have the energy I used to.				
I am fine. My family complains, but it is not a big issue.				
When I am tired, I get emotional or angry easily.				
I do not remember what happened while I was tired.				
I'd rather sit on the couch and watch TV all day than do anything.				
I cannot find my car keys.				
Loud noises bother me.				

Cognitive Symptom Checklist – Part 3

Please indicate in the column if the symptom is experienced or observed.
S = Survivor
C = Caregiver/Family Member
SP = Service Provider

Symptom	S	C	SP	Comments
I get off-topic easily.				
At the end of my day, I am not sure what I spent all my time doing.				
I cannot remember conversations.				
I have thoughts spinning around my head but cannot catch them.				
I get distracted very easily.				
When I am tired, I get confused easily and I cannot remember things.				
I cannot focus on anything for more than a few minutes.				
I start laundry but forget it in the washer.				
If someone gives me a deadline, I get frazzled and do not know where to start.				
If there's a lot going on, it is hard to focus on one thing (e.g., watching my child at a swimming pool).				
When I talk to more than one person, I find that conversation moves too fast for me.				

Symptom	S	C	SP	Comments
I am overwhelmed by details when I try to decide something (e.g., what brand of pan to buy). I either give up or do something quickly and regret it later.				
I have a day planner or smartphone but I always lose it.				
I reach the 'end of my rope' quicker than I used to.				
Sometimes, I feel stupid.				
When I am tired, I get emotional or angry easily.				
I have no idea how to start conversations with people I do not know well.				
I cannot remember if I paid the bills.				
I get sidetracked from important tasks by things that aren't urgent. For example, I might forget to pick up my kids because I remembered that I wanted to paint the bedroom and went to get paint.				
I feel like people are annoyed at me a lot.				
It is hard to apply strategies (e.g., resting) when I am in the middle of a busy day.				
I do not always realize when I've hurt someone's feelings.				
I am uncomfortable talking to people unless I know them well.				

Symptom	S	C	SP	Comments
I am sad.				
I do not care about things the way I used to.				
I'd rather sit on the couch and watch TV all day than do anything.				
I do not always think before I act.				
I am often nauseous.				
I cannot seem to start something unless someone else asks or directs me to.				
I was like this before the injury.				

Intervention Agreement

As per_____ consent, _____ will perform rehabilitation assistant services as per the following specifications:

1. Please refer to the enclosed intervention chart, strategy lists, and task routines for a detailed review of the intervention recommendations.

2. Documentation/communication:

3. Safety/Social issues:

4. Update Meetings:

5. Frequency of intervention:

By signing this service agreement, I represent that I have read/reviewed and understand it, and the associated documentation. This intervention agreement and plan have been reviewed with and agreed upon by all parties.

_____	_____
Client	Date
_____	_____
Service Provider 1	Date
_____	_____
Service Provider 2	Date

Awareness-Building Worksheet

Date:

Goals
1.
2.
3.

Morning Questions
Time:

Goal	Questions
1.	● Why is it important to _____? ● Do you think that you will follow through with_____ today? ● What could happen that will make it difficult for you to follow through with_____ today? ● What can you do to help ensure you follow through with_____?
2.	● Why is it important to _____? ● Do you think that you will follow through with_____ today? ● What could happen that will make it difficult for you to follow through with_____ today? ● What can you do to help ensure you follow through with_____?
3.	● Why is it important to _____? ● Do you think that you will follow through with_____ today? ● What could happen that will make it difficult for you to follow through with_____ today? ● What can you do to help ensure you follow through with_____?

Evening Questions
Time:

Goal	Questions
1.	● Why is it important to_____? ● Did you _____ today? ○ If yes, what did you do to ensure that you followed through? ○ If no, what can you do next time to ensure you follow through? ● How happy are you with your follow-through skills today?
2.	● Why is it important to_____? ● Did you _____ today? ○ If yes, what did you do to ensure that you followed through? ○ If no, what can you do next time to ensure you follow through? ● How happy are you with your follow-through skills today?
3.	● Why is it important to_____? ● Did you _____ today? ○ If yes, what did you do to ensure that you followed through? ○ If no, what can you do next time to ensure you follow through? ● How happy are you with your follow-through skills today?

Activities Planned/Activities Completed Worksheet

Date:

What activities do you plan to complete today/this week?	What activities did you complete today/ this week?

1. Highlight the tasks you successfully completed. Why do you believe you were able to complete them?

2. Review the tasks you did not complete. Why were you unable to do so?

Fatigue Rating Scale

Date: **Hours Worked:**

Activities Completed

Anticipated Performance

How well do think you will manage your fatigue today?1 (no problems) – 5 (exhausted by the end of the day)	
What strategies will you use to ensure that you manage your fatigue today?	

Tracking Fatigue

Fatigue Scale	
1	• No problems
2	• Fatigue is difficult to notice, but you are beginning to make mistakes and become distracted. • If you take a short break (i.e., 5 minutes), or change your activity, you can continue to work.
3	• You are finding it difficult to stay focussed. • You are becoming impatient, find your thoughts wandering, are making mistakes, and feel slightly 'overwhelmed.' • You need a break before you continue your day.
4	1. You need to take a total break (sleep or quiet time) before you continue your day. 2. (For example, you wouldn't be able to go out to dinner without having a nap first.)
5	• You are completely exhausted. • You need to end your day and go to bed.

Fatigue Rating	**Enter a rating for the corresponding time based on the Fatigue Scale**
Fatigue level at	
Fatigue level at	
Fatigue level at	
Fatigue level at	

Tracking Symptoms

Fatigue-Related Symptoms	Check each symptom experienced today
	☐
	☐
	☐
	☐
	☐
	☐
	☐
	☐
	☐
	☐

Reflection

How well did you manage your fatigue today? 1 (no problems) – 5 (exhausted by the end of the day)	
What could you do differently?	

Conversation Planning Worksheet

Date:
Name of the person you want to speak with:

What do you know about them? **What do they talk about at work?**	
What kinds of questions can you ask (or topics can you bring up) based on what you know about them and their interests?	
How will you end the conversation?	

Right/Wrong Chart

Date:
Problem:
Potential Solutions:

What could go right?	What could go wrong?
Can I live with the result?	

Consider the following when making your plan:

Reflect
Which solution did you choose?
How did it work?
What would you change?

Goal, Plan, Do, Review

Date:

GOAL	**What are you trying to accomplish?** S – Specific M – Measurable A – Attainable R – Realistic T – Time-limited **Is this going to be easy or difficult?**	
PLAN	**How do you plan to get this done?** **What do you need?** **What are the steps?** **How long will it take?**	
DO	**Carry out your plan.**	
REVIEW	**Did you meet your goal?** **What worked?** **What didn't?** **What was easy?** **What was difficult?** **How will you approach it differently next time?**	

Prioritization Chart

Date:
Question List

Tasks	Necessary	Important	Would be Nice

Safety Workbook

Table of Contents

1. **Overview**
2. **Emergency Contacts**
3. **Medical Information**
4. **Exit Routes**
5. **Emergency Procedures and Plans**
    - **smell of gas in the home**
    - **fire has started (daytime)**
    - **fire alarm sounding**
    - **intruder in the home**
    - **home has flooded**
    - **electricity is out**
    - **locked out of the home**
    - **fallen/injured self**
    - **child is injured**
    - **child has ingested dangerous product (poison control)**
    - **child is ill through the night**
    - **Other:**
6. **Fire**
7. **Utilities**
8. **Emergency Kit**

EXIT ROUTES

Plan/map emergency exits from each room of the house. Practise them while carrying your child. Draw up a floor plan - try to identify two escape routes from each room.

FIRE

1. **Find the fire extinguishers through the home. Where are they located?**
2. **Learn how to use a fire extinguisher. Practise using it, and record the directions here. *Do not try to fight a fire yourself. Get out and call for help.***
3. **Check smoke alarms. You should have at least one on every floor of your home. Clean them at least once monthly and test them at least once (preferably twice) each year. Change the batteries yearly if they are disposable. Where are they located?**
4. **Telephone the local fire department. Register to inform them of any special needs. (Simply telephone the fire department, and inform them that you require additional assistance in case of an emergency. Provide them with your name and address.)**
5. **Check for potential hazard spots in the home. Ordinary items such as bookcases, hanging pictures, or lights can cause fires or block escape routes during an emergency.**

UTILITIES

1. **Review how to turn off water, gas, and electricity at main valves or switches. Make large, easy-to-see signs for water and gas shut-offs, as well as for the breaker panel or fuse box. If you are experiencing an urgent although non-emergency situation, telephone the pertinent telephone number and follow directions.**

MEDICAL INFORMATION

1. **Fill in the medical information forms and store the information in an easy-to-access location.**

EMERGENCY CONTACTS

1. **Fill in the emergency contact forms and store the information in an easy-to-access location.**

EMERGENCY KIT

1. **Prepare an emergency kit.**

MEDICAL INFORMATION

Name	
Allergies	
Medical History	
Special Needs	
Medications	
Physician	
Physician Telephone	
Physician Address	
Other:	
Name	
Allergies	
Medical History	
Special Needs	
Medications	
Physician	
Physician Telephone	
Physician Address	
Other:	

*** Remember; dispose of any old or out-of-date prescriptions. The chemicals inside medicines can change over time.*

Emergency Service (report a fire, report a crime, save a life)	**Telephone Numbers**
Police	
Fire	
Ambulance	
Other:	

Non-Emergency Service	**Telephone Number**
Police	
Fire	
Ambulance	
Poison Control	
Hospital	
Health Clinic	
Other:	

Primary Emergency Contact Name	
Home phone	
Work phone	
Cellular phone	
Email address	
Work address	

Secondary Emergency Contact Name	
Home phone	
Work phone	
Cellular phone	
Email address	
Work address	

Emergency: You smell gas in the home.

What should you do?	*Who should you call/contact?*	*Phone Number*	*What should you tell them?*

Emergency: A fire has started (during the day).

What should you do?	*Who should you call/contact?*	*Phone Number*	*What should you tell them?*

Emergency: The fire alarm is sounding (at night or during the day).

What should you do?	*Who should you call/contact?*	*Phone Number*	*What should you tell them?*

Emergency: An intruder is in the home.

What should you do?	*Who should you call/contact?*	*Phone Number*	*What should you tell them?*

Emergency: The home has flooded.

What should you do?	*Who should you call/contact?*	*Phone Number*	*What should you tell them?*

Emergency: The electricity has gone out.

What should you do?	*Who should you call/contact?*	*Phone Number*	*What should you tell them?*

Emergency: You have locked yourself out of the house.

What should you do?	*Who should you call/contact?*	*Phone Number*	*What should you tell them?*

Emergency: You have fallen or have otherwise injured yourself.

What should you do?	*Who should you call/contact?*	*Phone Number*	*What should you tell them?*

Emergency: Your child has injured him/herself (fall, deep cut, large bruise, severe swelling).

What should you do?	*Who should you call/contact?*	*Phone Number*	*What should you tell them?*

Emergency: Your child has ingested a dangerous product (cleaning supplies, medications, etc.).

What should you do?	*Who should you call/contact?*	*Phone Number*	*What should you tell them?*

Emergency: Your child is ill through the night.

What should you do?	*Who should you call/contact?*	*Phone Number*	*What should you tell them?*

Emergency:

What should you do?	*Who should you call/contact?*	*Phone Number*	*What should you tell them?*

WATER VALVE

Shut-off instructions:

Utility company phone number:

ELECTRICAL BOX

Utility company phone number:

GAS VALVE

Shut-off instructions: (Only shut off gas when authorities tell you to do so)

Utility company phone number:

FLOOR DRAIN

Location:

EMERGENCY KIT

1. **Prepare an emergency 'grab-and-go' backpack. Consider including the following items:**

   - **bottled water**
   - **non-perishable food**
   - **first aid kit**
   - **extra house or car keys**
   - **money**
   - **flashlight and spare batteries**
   - **blankets**
   - **change of clothing**
   - **child care supplies (such as spare diapers, change of clothing, formula/ food, etc.)**

Budgeting Worksheet

Date:
Savings:

Money Saved to Date		Saving Goals	If saving for an item, what is the cost?

Income:

Date	Amount	Source
Total		

Expenses:

Expense	Amount	Notes
Total		
Total Income		
Balance		

****Review your online banking records once weekly to confirm that you are on track.

Financial Tracking Form

Month:

Monthly Payments	Check When Paid

Message Pad

Date:

Message	Notes	Completed

Daily Planning Strategy List

Week:

Daily Planning Routine	Check if completed						
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Employer Evaluation Form

Week: **Name:**

Rate *the employee* on a scale from **1 (no problems noted) to 5 (significant difficulty observed)** when considered in comparison to a competitive employee

Areas of Performance	Rate Performance				
	Mon	**Tues**	**Wed**	**Thurs**	**Fri**
Completes tasks as requested					
Completes multi-step activities successfully: One-step Two-step Three(+)-step					
Appears attentive when provided with education					
Presents in a motivated and respectful manner					
Identifies the need for help and requests assistance					
Tasks are completed without a requirement for cueing or redirecting (i.e., memory issues, ability to stay on task)					
Consistently reviews work					
Presents with accurate attention to detail					
Maintains concentration despite environmental distractions					
Adheres to safety protocols					
Demonstrates appropriate and professional work behaviour					
Demonstrates appropriate and professional work attire					
Demonstrates appropriate and professional interaction with team members					
Accepts constructive criticism in a calm, appropriate manner					

Areas of Performance	Rate Performance				
	Mon	Tues	Wed	Thurs	Fri
Uses provided criticism to improve performance					
Manages frustration appropriately					
Arrives at work on time					
Maintains focus and participates in work activities for the full shift					
Follows an organized work routine					
Prioritizes work tasks appropriately					
Presents with appropriate and timely responses to any given request					
Completes tasks within required timeframes					
Retains and applies previously learned material					
Effective communication skills					
Uses required tools/technology in an appropriate manner					

1. **In the event that any concerns arose, please provide further detail.**

2. **What recommendations/feedback was provided to the client in order to address the issue?**

3. **Did the employee effectively address the presented issue?**

4. **Please list examples of the employee's overall strengths, weaknesses, and general areas for improvement.**

Employee Evaluation Form

Week:

Rate yourself on a scale from **1 (no problems noted) to 5 (significant difficulty observed)** when considered in comparison to a competitive employee

Areas of Performance	Rate your Performance				
	Mon	**Tues**	**Wed**	**Thurs**	**Fri**
Complete tasks as requested					
Complete multi-step activities successfully: one step two step three (+) step					
Appear attentive when provided with education					
Present in a motivated and respectful manner					
Identify the need for help and request assistance					
Tasks are completed without a requirement for cueing or redirecting (i.e., memory issues, ability to stay on task)					
Consistently review work					
Present with accurate attention to detail					
Maintain concentration despite environmental distractions					
Adhere to safety protocols					
Demonstrate appropriate and professional work behaviour					
Demonstrate appropriate and professional work attire					
Demonstrate appropriate and professional interaction with team members					
Accept constructive criticism in a calm, appropriate manner					

Areas of Performance	Rate your Performance				
	Mon	Tues	Wed	Thurs	Fri
Use provided criticism to improve performance					
Manage frustration appropriately					
Arrive at work on time					
Maintain focus and participate in work activities for the full shift					
Follow an organized work routine					
Prioritize work tasks appropriately					
Present with appropriate and timely responses to a given request					
Complete tasks within required timeframes					
Retain and apply previously learned material					
Effective communication skills					
Use required tools/technology in an appropriate manner					

1. **In the event that any concerns arose, please provide further detail.**

2. **What recommendations/feedback was provided to you in order to address the issue?**

3. **Did you effectively address the presented issue?**

Work Skill Rating Log

Week:
Anticipated Performance

How well do you expect to manage your symptoms this week? 1(no problems) – 5 (significant problems)	
What strategies will you use?	

Tracking Work Performance
Rate yourself on a scale: **1 (no problems) to 5 (very difficult)**

Work Skill	Mon	Tues	Wed	Thurs	Fri

Tracking Symptoms
Rate yourself on a scale: **1 (symptom not experienced) to 5 (symptom was severe)**

Symptom	Mon	Tues	Wed	Thurs	Fri

Reflection

How well did you manage your symptoms this week? 1(no problems) – 5 (significant problems)	**Reflection**
What could you do differently?	

Daily Work Routine

Week:

Tasks	Check if completed						
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Remember:

Cash Chart

Date:

Denomination	**How Many Coins or Bills?**	**Multiply**	**Total**
Nickels ($0.05)		x .05 =	$.
Dimes ($0.10)		x .10 =	$.
Quarters ($0.25)		x .25 =	$.
Loonies ($1.00)		x 1.0 =	$ .00
Toonies ($2.00)		x 2.0 =	$ .00
Five-dollar bills ($5.00)		x 5.00 =	$ .00
Ten-dollar bills ($10.00)		x 10.00 =	$ .00
Twenty-dollar bills ($20.00)		x 20.00 =	$ .00
Fifty-dollar bills ($50.00)		x 50.00 =	$ .00
Hundred-dollar bills ($100.00)		x 100.00 =	$ .00
	When you have counted all the bills and coins, and have calculated the totals, **add together all the numbers from the 'Total' Column.**		
		SUB-TOTAL =	$.
Gift Certificates (add the total of all the gift certificates sold today)	**Total:**	**Subtract** gift certificate total from above total	$.
		TOTAL =	$.