The following forms are found in this appendix, in the following order:

- **Request for Services Form** – This is the screening form used when clients first request services.

- **Intake Information for Clients** – Disclosure and informed consent. Must be signed by the client at the beginning of the first session.

- **Consent for Research Participation** – Form used to request client permission to use their session information in research – do not use unless instructed to.

- **Intake Questionnaire** – Basic information questionnaire that clients must fill out at first session - and which you must review before you begin counseling in the first session.

- **Mental Status Exam Checklist** – Checklist of items. To be completed by hand after first session.

- **Intake Summary / Intake Summary Guidelines** – Form to summarize basic client information, clinical impressions, diagnosis, and treatment plans. Must be completed before the third session.

- **Session Note** – Form to document the content and process of clinical sessions, as well as no-shows.

- **Session Note – Play Therapy** – Form to document content and process of Play Therapy sessions

- **Group Session Note** – Form to document the content and process of group counseling sessions.

- **Outcome Rating Scales / Session Rating Scales** – Forms used at the end of each session to track client progress and quality of the Therapeutic Alliance. Both ORS and SRS should be used after each session. Select the form that best fits the client’s developmental level. The Leeds Alliance in Supervision Scale is used after each supervision session.

- **Contact Note** – Form to document non-session contact with clients and others, including cancellations.

- **Service Plan** – Form to document client resources, and working goals. To be completed during the third session, and reviewed (with a new form) every 30 days.

- **Closing/Transfer Summary** – Form to close a case, required for all clients who were seen in the clinic.

- **Client Feedback Form** – Form mailed to clients after their file is closed for feedback about the counselor.

- **Consent to Bi-lateral Release of Information** – Forms to use to receive permission to exchange information with other professionals – second form is just for use with lab-school child clients.
• **Information about Substance Use Assessments** – Informational form to share with clients before an ASI.

• **ASI Interview** – The structured interview for conducting an ASI evaluation.

• **ASAM Placement Criteria Summary** – Form to be used after ASI to assist in making treatment recommendations for clients with substance use issues.

• **Sample Court Letter** – This letter is used to send the results of a substance abuse evaluation to a judge.

• **Client Safety Plan** – Form to fill out with a client who needs some specific direction and focus for staying safe when feeling suicidal.

• **Counseling Student's Clinical Log** – Form used to document clinical and supervisory hours during one semester.

• **Counseling Student's Clinical Log – Summary** – Form used to summarize clinical and supervisory hours across your whole program.

• **Counseling Skills Evaluation Form** – Form used by supervisors at mid and end of term to evaluate student’s clinical skills.

• **Counselor Evaluation of the Supervisor Form** – Form used by students to give written feedback to their supervisors.

• **Supervision Note** – Form used by supervisors to document what takes place in supervision.

• **CETC Organizational Chart** – Chart overview of clinic management roles.
Request for Services

Name: __________________________  Date Contacted: __________________________
Age: __________________________  □ Female  □ Male
Phone Number: __________________________  Okay to leave message? □ Yes  □ No

Best time for someone to reach you at this number: ______________________________________

Reason for contacting the clinic (in person’s own words): ______________________________________

1. Informed consent: Services are provided by a clinical team – all sessions are videotaped, observed by other clinicians and professional supervisors, strict confidentiality maintained.
   □ Person agrees to receive services as described
   □ Person does not agree to receive services, referred to: ______________________________________

2. Referral Source: ______________________________________

3. Reason for Referral: ______________________________________

4. Previous Counseling History: ______________________________________

5. Currently receiving Counseling: □ No  □ Yes  ______________________________________
   Inform we don’t provide concurrent services unless in a different modality (group, family, etc)

6. Risk Assessment – If suicidal ideation is present, refer to a 24-hr crisis service (742-0285 – IMH)
   Suicidality / Self-Harm
   Past thoughts: □ No  □ Yes, describe ______________________________________
   Past actions: □ No  □ Yes, describe ______________________________________
   Current thoughts: □ No  □ Yes, describe ______________________________________
   Current actions: □ No  □ Yes, describe ______________________________________

   Homicidality / Harm to others
   Past thoughts: □ No  □ Yes, describe ______________________________________
   Past actions: □ No  □ Yes, describe ______________________________________
   Current thoughts: □ No  □ Yes, describe ______________________________________
   Current actions: □ No  □ Yes, describe ______________________________________
7. Substance Abuse History, gathered to assist in appropriate placement in clinic
   □ Denied   □ Acknowledged – briefly describe (what substances, amount, duration, past treatment)

8. Thought Disturbances: □ No   □ Yes
9. Orientation: □ Time   □ Place   □ Person
10. Possible Dual Relationship Concerns – currently taking a counseling course, knows counselor in clinic
    □ Denied   □ Acknowledged
11. Readiness for Change Scale (self-rated)   _____ 1 = not sure about counseling, 5 = been wanting counseling for a while
12. Times available for 50 min. counseling appointments:
    Mondays: 
    Tuesdays: 
    Wednesdays: 
    Thursdays: 
    Fridays: 
13. Appropriateness of person for CETC Services:
    □ Master's Pre-Practicum
    □ Master's Practicum
    □ Master's Child & Adolescent Course
    □ Doctoral Practicum
    □ ASI Evaluation
    □ Client Assigned to: 
    Date Counselor Informed: 
    □ Not appropriate for CETC Services
        Reason: 
        Referred to: 

Notes:

Clinic Coordinator Signature   ________________________  Date ________________________
Intake Information for Clients

Introduction: Welcome to the Counselor Education Training Clinic. This disclosure statement is required by the Mental Health Professions Licensing Act, and is designed to give you important information about the services we provide. Please read it carefully, and ask your counselor if you have any questions. The counselors at the CETC are graduate students at the University of Wyoming working toward an advanced degree in Counseling. They are qualified to provide the full range of services we offer (individual, couples, family and group counseling, as well as substance abuse evaluations) under supervision. The clinic is open during fall and spring semesters, 5 days a week for scheduled appointments only. Although there is no charge for counseling, there is a $50 fee for substance abuse evaluations to cover the cost of forms and copying. Your counselor's name is: _____________________________. All counselors-in-training are directly supervised both by qualified doctoral students, and by the clinical faculty of the Counselor Education department. Supervisors monitor counseling cases, provide clinical support and feedback to the counselors. Your counselor’s supervisor is: _____________________________.

Goals and Outcomes: Counselors help individuals help themselves or improve their relationships by assisting them to change their feelings, thoughts and/or behaviors. Your counselor will likely explore with you new ways to look at things and new things to do, and will support you in the process of making changes. Ultimately, however, you will decide the nature and amount of change you wish to make. Your counselor will discuss your progress throughout counseling. If at any time you are unhappy with your progress, or the direction your counselor is taking, please talk about it with your counselor. This is so important to us, that at the end of each session, your counselor will ask you for some feedback on how you are doing and how the counseling is going. Research shows that this kind of feedback can lead to quicker and better change for you, the client. Your counselor will briefly discuss the feedback with you so that together you can make adjustments to your counseling that will best meet your needs. Please be as open and honest about how things are going as you can – your counselor wants to know, and won’t be hurt if you think things aren’t going well.

Typically sessions occur weekly and last 50 minutes. We request that you make a commitment to participate in at least four weekly sessions. The actual duration and frequency of counseling will depend upon your specific goals. Your counselor will be available to meet with you until the week of ______________, when their practicum/internship experience will end. At that time your counselor will assist you with appropriate recommendations. If interested, you may have the opportunity to continue your counseling next semester. You have the right to leave counseling at any time. However, it is usually best to do so only after discussing possible risks with your counselor. If at any point you feel like you want to end counseling, please let your counselor know.

Benefits and Risks: Most people experience improvement or resolution to the concerns that brought them to counseling. However, the process of counseling can be difficult sometimes. Discussing psychological, emotional, and/or relationship issues occasionally causes some pain and anxiety, and making important changes will require effort on your part. You are more likely to see improvement when you are willing to be open and work through difficult issues, even when doing so is hard. Your counselor will support you in addressing these issues.

Confidentiality and Limits to Confidentiality: Trust and honesty are critical to the development of all counseling relationships. Therefore, we place a high value on privacy and the confidentiality of information you share in counseling. Wyoming Statute 33-38-113 provides privileged status for counselor-client communications. The confidentiality of client records maintained by this clinic is protected by federal law and regulations (See 42 U.S.C. 290dd-3, 42 U.S.C. 290-cc, 42 CFR part 2, and 45 CFR part 160 & 164). Your counselor, supervisors, and the clinical team will not disclose any information that you communicate without your express written consent, except in the following situations, as allowed by the law:

1. Where an immediate threat of self-inflicted harm exists;
2. Where an immediate threat of physical violence against a readily identifiable victim exists;
3. Where there is reasonable suspicion of abuse/neglect against a child, elder, or other dependent adult;
4. Where a judge has ordered the release of privileged information;
5. In the course of criminal or civil actions initiated by you against the counselor;
6. The disclosure is made to medical personnel in a medical emergency;
7. Where the client alleges mental or emotional damages in civil litigation or otherwise places his mental or emotional state in issue in any judicial or administrative proceeding concerning child custody or visitation;

Your Relationship with your Counselor: Although you may share personal information with your counselor during the course of counseling, your relationship must remain professional. The focus of counseling will be on your experiences, concerns and goals. Sexual intimacy between counselor and client is never appropriate.
**Video/Audio-recording:** As a training clinic, we can offer our clients some services that other places do not. One of these is the use of a clinical team. These are other counselors-in-training, along with an experienced clinical supervisor. These clinicians may observe some of your sessions live, and provide feedback to your counselor and/or to you—your counselor may take a break mid-session to consult with the team, or the team may phone into the room to share their ideas. We believe that having several clinicians working on the same case improves the services you receive, while also helping our counselors improve. In addition, your counselor will be recording (video/audio) all sessions. These recordings are used in the counselors’ ongoing professional training and regular supervision to improve the services you receive. These recordings are treated with the strictest confidentiality and professionalism. The counselor, supervisors, department faculty members, and clinical team are the only ones with access to recorded sessions, and all recordings are erased at the end of the academic school year. Any other use of these recordings requires your written consent first.

**Your Responsibilities:** You can help make counseling successful by attending all scheduled sessions, making a sincere effort to work on the identified issues, and following through with elements of counseling such as readings, tasks to do between sessions, etc. Attending counseling while under the influence of any mood altering substance prevents any progress. If it becomes clear that you are under the influence, we will end the session and reschedule for a future date. A repeat occurrence will result in the termination of services (with referrals). Violent or threatening behavior may also result in termination of services and a police report. If you are court-ordered to obtain counseling, you are responsible to bring a copy of the full court order to your counselor no later than the second session. If for some reason you cannot attend a scheduled session, please call in advance. Counselors’ schedules are rather full and if clients do not cancel appointments with sufficient time, it means that others who could receive services are unable to. Repeated failures to attend sessions or to provide adequate rescheduling notice may lead to termination of services. ✴ Confidential messages may be left at 766-6820.

**Client Rights:** Services are available to all persons regardless of sex, race, color, creed, sexual orientation, handicap and age, in accordance with state and federal laws. You have a right to humane and dignified treatment, courteous and respectful care in safe environment. You have a right to understand and participate in your evaluation and treatment. Please know that the CETC is a tobacco free site.

**Grievance Procedures:** If you have any concerns about your counseling or anything else that happens at the CETC, please discuss them with your counselor, their supervisor, or the Clinic Director. To speak with the supervisor, or Clinic Director, please contact Dr. Michael Morgan (Clinic Director) at (307) 766-7657. If we are not able to help you resolve your concerns, or you wish to obtain further information or report a complaint, you may contact the Wyoming Mental Health Professions Licensing Board, 1800 Carey Avenue, Fourth Floor; Cheyenne, WY 82002; (307) 777-3628 &/or the Wyoming Mental Health and Substance Abuse Services Division, (800) 535-4006. If you are not satisfied with the results of this process, you can make a formal complaint in writing to the Behavioral Health Division, 6101 Yellowstone Rd, Suite 220, Cheyenne, WY 82002.

**Screening and Emergency Resources:** The CETC does not provide emergency services or 24 hour care. Part of the first session will be used to determine if the services we provide meet your needs. If not, we will help you make connections with other providers that can meet your needs. Due to the limited availability of counselors, sessions are only offered one time per week. If you need additional support services beyond what you are receiving, please discuss this with your counselor. If an emergency arises, please contact one of the following resources:

- **University Counseling Center (UCC)**
  340 Knight Hall - 766-2187  
  ►After-Hours Crisis Line: 766-5179

- **Peak Wellness Center**
  1263 North 15th Street - 745-8915  
  ►After-Hours Emergency: 745-8915

- **Ivinson Memorial Hospital**
  ►Emergency Services: 742-0285

**Statement of Agreement:**

I have read the information on both pages of this document, have had the opportunity to ask and receive answers to any questions I had, and understand the information and how it relates to my counseling experience. By signing below I voluntarily agree to the services and provisions specified above.

<table>
<thead>
<tr>
<th>Client Signature</th>
<th>Date</th>
<th>Parent/Guardian (if client is a minor)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Signature</td>
<td>Date</td>
<td>Counselor Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Client Signature</td>
<td>Date</td>
<td>Supervisor Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

**Revised 2012.08**
Consent for Research Participation

One of our goals at the Counselor Education Training Clinic is to improve our understanding of the counseling process. We want to better understand our clients’ needs, how to best help our clients, and how we can improve counselor training. We do this (when clients give us permission) by carefully reviewing session recordings and looking at information we already gather from clients as part of their counseling (such as the types of client concerns, number of sessions, how counseling is going, what works, and what they want to be different). These studies are conducted by faculty members in the UW Department of Counselor Education.

Risks: Your risk for giving us permission to include your information in our ongoing studies is minimal. If you decide to participate, your counseling services will not be any different than if you choose not to give permission. The research uses the same information (recordings and client forms) that are a regular part of how we provide counseling services to all of our clients. Clients who give permission for their information to be used in our studies are protected by the same confidentiality agreement as all our clients. Only the clinical faculty and student clinicians / supervisors have access to any of this information. It all remains secure in our clinic (as specified on the Intake Information for Clients form), and is destroyed / deleted as soon as possible, but no longer than five years after the end of services. Any scholarly publications or presentations that come from our research will not contain any information that could be used to identify you as a participant. Session recordings cannot be used in presentations without your written permission on a separate form.

Benefits: Your decision to allow us to use your session recordings and other information may help us improve the services we provide to all our clients, as we better understand the counseling process. As we share the results of our research, other counselors and counselor educators may also improve the services they provide. You will be helping advance the field of counseling. However, since we already gather and use the same information as part of our regular counseling services, you will not receive any additional personal benefit from participating in the study.

Please understand that your decision to participate or not participate in these ongoing studies will not impact the counseling services you receive in any way. You are also free to change your mind and either grant or withdraw permission at any time, with no consequences at all. If at any time you want to change your decision, just ask your counselor for a new form.

By checking a box and signing below, I acknowledge that I have read this consent form and have had all my questions satisfactorily answered, so that I fully understand my choice and how it will / will not affect my counseling at the CETC. I am aware that if I have any questions or concerns, I can speak with my counselor, their supervisor, or the Clinic Director, Michael Morgan at (307) 766-2366.

□ I do give permission for my counseling information to be used in research as specified above.
□ I do not give permission for my counseling information to be used in research.

Client's name (printed)_________________________Client's Signature_________________________

Today's Date: _______________________________
Counselor Education Training Clinic

C. E. T. C.

Helping Individuals, Couples, and Families to Thrive

Counseling Intake Questionnaire

► Please fill this form out completely. The information will help your counselor begin to understand you and help you.

Client Name: ____________________________ Date of Birth: ______________

Local address: __________________________________________________________

Phone where you can be reached: ______________ e-mail: ____________________

Relationship Status:

☐ Single  ☐ Married  ☐ Partnered  ☐ Separated  ☐ Divorced  ☐ Widowed

Who do you currently live with? _____________________________________________

Current Occupation: _______________________________________________________

Briefly describe the reason you decided to seek our services:

__________________________________________________________________________

Have you ever received services for a mental health concern? This includes prior counseling, medication, hospitalizations, etc.)

☐ Yes  ☐ No

If yes, please tell us when, where, for how long, and for what reason:

__________________________________________________________________________

List any physical health problems for which you currently receive treatment:

__________________________________________________________________________

__________________________________________________________________________

Are you currently taking any prescribed medications or over-the-counter supplements to deal with a physical or emotional health concern? ☐ Yes ☐ No

Medication / Supplement Name __________________________ Dosage __________________________ Intended Purpose __________________________

__________________________________________________________________________

When was your last physical examination? ____________________________
Please check (✓) any / all of the following that you are currently experiencing:

□ Relationship Difficulties
  □ Marital / Partner problems
  □ Communication problems
  □ Remarried family problems
  □ Difficulty with In-laws
  □ Problems with your parents
  □ Sexual relationship difficulties
  □ Brother / Sister problems
  □ Separation
  □ Divorce
  □ Dating difficulties
  □ Premarital issues
  □ Difficulties with friends

□ Emotional Difficulties
  □ Depression
  □ Suicidal thoughts
  □ Suicidal actions
  □ Sadness
  □ Unhappiness
  □ Nervousness or panic attacks
  □ Anger / Temper difficulties

□ Situation Difficulties
  □ Death of a loved one
  □ Violence (real or threatened)
  □ Physical abuse (past or current)
  □ Sexual abuse (past or current)
  □ Legal problems
  □ Major losses / difficult changes
  □ Stress
  □ Past difficulties still causing problems
  □ Difficulties with religion / spirituality
  □ Difficulties making decisions

□ Physical Health Difficulties
  □ Headaches
  □ Stomach problems
  □ Physical disability
  □ Bed-wetting
  □ Eating problems
  □ Sleep problems
  □ Ongoing physical pain

□ Difficulties with Children
  □ Child's misbehavior
  □ Child's emotionality
  □ Parenting concerns

□ Work / School Related Concerns
  □ Unemployment
  □ Problem at work / school
  □ Education
  □ Finances
  □ Career choices
  □ Learning Disability

□ Personality Concerns
  □ Fears
  □ Low self-esteem
  □ Loneliness
  □ Shyness
  □ Sexuality concerns
  □ Guilt
  □ Confusion
  □ Assertiveness
  □ Relaxation
  □ Self-control
  □ My thoughts
  □ Compulsive behavior
  □ Alcohol / Drug use concerns

Please list the three items from above that are causing you the most difficulty / concern:
1 __________________________ 2 __________________________ 3 __________________________

Please list family, friends, support groups or others that are helpful and supportive for you:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
Difficulties with Coping: Please check (✓) any items that you are experiencing

☐ Sleep problems
☐ Difficulty falling asleep
☐ Waking in the middle of the night
☐ Waking too early
☐ Sleeping too much
☐ Nightmares
☐ Mood or crying more than usual
☐ Difficulties concentrating
☐ Problems remembering things
☐ Withdrawing from others
☐ Panic attacks
☐ Repeated actions I can’t stop (compulsions)
☐ Repeated thoughts I can’t stop (obsessions)
☐ People picking on me
☐ Self harm:
  ☐ I cut myself
  ☐ I burn myself
  ☐ I smash / hit myself
  ☐ Other self harm (________________)

☐ Change in appetite
☐ Gaining weight (specify ________ lbs)
☐ Losing weight (specify ________ lbs)
☐ Not hungry or not eating
☐ Throwing up after eating
☐ Feeling sick to my stomach
☐ Constipation or diarrhea
☐ Feeling guilty, worthless or hopeless
☐ Fatigue or low energy
☐ Hyper or too much energy
☐ Loss of interest in things
☐ Extreme worry or fears
☐ Low self-esteem
☐ Using alcohol / drugs to numb my feelings
☐ Hallucinations:
  ☐ I hear things that are not real
  ☐ I see things that are not real
  ☐ I smell things that are not real
  ☐ I feel things that are not real

List any previous suicide attempts (if none, write “None”)
When (month / year) __________________________ Method of attempt __________________________
________________________ __________________________
________________________ __________________________

Have you recently been thinking about hurting or killing yourself? ☐ Yes ☐ No
Have you recently been thinking about hurting or killing someone else? ☐ Yes ☐ No

Are you currently involved in any legal proceedings (arrests, charges, trial, probation, etc)
☐ Yes ☐ No
Briefly Describe:
________________________

Briefly describe your current use of alcohol (how much, how often, and what). If none, write "None."
________________________

Briefly describe your current use of drugs (how much, how often, what). If none, write "None."
________________________
Does anyone in your family have a history of mental health or alcohol/drug concerns?

☐ Yes  ☐ No

Please list and briefly describe:

_________________________________________________________

Have you ever experienced any of the following kinds of abuse in your own life?

☐ Physical abuse  ☐ Yes  ☐ No

☐ Emotional abuse  ☐ Yes  ☐ No

☐ Sexual abuse  ☐ Yes  ☐ No

☐ Rape  ☐ Yes  ☐ No

Do you feel safe right now?  ☐ Yes  ☐ No

What role does spirituality or religion currently play in your life?

_________________________________________________________

If you have a preferred spiritual tradition or religion, please indicate below (or write "None").

_________________________________________________________

Your counseling goal ideas:

Goals are very important in counseling. They give us a focus and direction that will help us to help you. Please list some of the major things that you would like to have us help you with (what do you want to have different in your life?).

1 _______________________________________________________

2 _______________________________________________________

3 _______________________________________________________

How many sessions do you think you might want / need to get back on track? ________________

Anything else you would like to share that will help your counselor understand you:

_________________________________________________________

_________________________________________________________

_________________________________________________________

Some people have questions about communicable diseases (STD / HIV).

Would you like information about, a referral for screening and/or for a connection with possible counselors related to those concerns?  ☐ Yes  ☐ No

Client Signature ___________________________  Date ________________

Parent/Guardian (if client a minor) ___________________________  Date ________________
# Mental Status Exam Checklist

**Client Name:**

**Date of Interview:**

<table>
<thead>
<tr>
<th>Appearance</th>
<th>1. Unusual clothing / grooming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Movement</td>
<td>2. Unusual speed, restlessness, fidgetiness</td>
</tr>
<tr>
<td>Facial Expressions</td>
<td>3. Incongruent to content of conversation</td>
</tr>
<tr>
<td>Speech</td>
<td>4. Unusual speed / volume / quality</td>
</tr>
<tr>
<td>Relationship to the Counselor</td>
<td>5. Controlling, hostile, provocative</td>
</tr>
<tr>
<td></td>
<td>6. Submissive, overly compliant, dependent</td>
</tr>
<tr>
<td></td>
<td>7. Suspicious, guarded, evasive</td>
</tr>
<tr>
<td></td>
<td>8. Uncooperative, non-compliant</td>
</tr>
<tr>
<td>Feeling (Affect and Mood)</td>
<td>9. Incongruent to content of conversation</td>
</tr>
<tr>
<td></td>
<td>10. High lability of affect</td>
</tr>
<tr>
<td></td>
<td>11. Blunted, dull, flat</td>
</tr>
<tr>
<td></td>
<td>12. Euphoria, elation (manic quality)</td>
</tr>
<tr>
<td></td>
<td>13. Depression, sadness</td>
</tr>
<tr>
<td></td>
<td>14. Anger, hostility</td>
</tr>
<tr>
<td></td>
<td>15. Anxiety, fear, apprehension</td>
</tr>
<tr>
<td>Thinking</td>
<td>16. Hallucinations (note type and content)</td>
</tr>
<tr>
<td>Intellectual Functioning</td>
<td>17. Impaired attention span, easily distracted</td>
</tr>
<tr>
<td></td>
<td>18. Impaired rational thinking / decisions</td>
</tr>
<tr>
<td></td>
<td>19. Impaired intelligence</td>
</tr>
<tr>
<td>Orientation</td>
<td>20. Disoriented: circle–Person, Place, Time</td>
</tr>
<tr>
<td>Memory</td>
<td>21. Impaired memory: circle–Recent, Remote</td>
</tr>
<tr>
<td>Judgment</td>
<td>22. Denies presence of problems</td>
</tr>
<tr>
<td></td>
<td>23. Blames situation / others for problems</td>
</tr>
<tr>
<td></td>
<td>24. Impaired impulse control</td>
</tr>
<tr>
<td>Thought Content</td>
<td>25. Obsessions / Compulsions (circle and note)</td>
</tr>
<tr>
<td></td>
<td>26. Phobias (specify)</td>
</tr>
<tr>
<td></td>
<td>27. Delusions (note type and content)</td>
</tr>
<tr>
<td>Risk Status</td>
<td>28. Suicidal ideation</td>
</tr>
<tr>
<td></td>
<td>29. Homicidal ideation</td>
</tr>
<tr>
<td></td>
<td>30. Domestic violence</td>
</tr>
<tr>
<td></td>
<td>31. Problematic alcohol use</td>
</tr>
<tr>
<td></td>
<td>32. Illicit drug use</td>
</tr>
</tbody>
</table>

**Comments:**

____________________________________________________________________________________

____________________________________________________________________________________

Counselor Signature: ___________________________  Supervisor Initials: ______________________
Intake Summary

Client Name:  Click here to enter text.  Date:  Click here to enter a date.
Counselor:  Click here to enter text.

I. Identification of Client and Problem:
   Click here to enter text.

II. History of Present Difficulties:
   Click here to enter text.

III. Relevant Background Information:
   Click here to enter text.

IV. Psychosocial Adjustment / Strengths and Resources:
   Click here to enter text.

V. Case Conceptualization:
   Click here to enter text.

DSM Diagnosis:
   Click here to enter text.
Axis 1:  Click here to enter text.
Axis 2:  Click here to enter text.
Axis 3:  Click here to enter text.
Axis 4:  Click here to enter text.
Axis 5:  GAF – Current =  Click here to enter text.
   GAF – Best in Past Year =  Click here to enter text.

VI. Initial Treatment Plan:
   Click here to enter text.

Counselor Signature  Date  Supervisor Signature  Date
Intake Summary - Guidelines

This sheet explains what you need to write in each section of the intake summary.

I. Identification of Client and Problem:
   Include basic identifying information (age, sex, relationship status, ethnic background, whether a
   parent, occupation, other pertinent identifying information). Indicate who referred the client for services
   (physician, clergy, other agency, etc), and why the client was referred, or state that the client self-
   referred. Capture as nearly as possible what the client describes as their reasons for seeking services
   (including current symptoms).

II. History of Present Difficulties:
   How long has the client experienced the current problem? Has it been continuous? intermittent? What
   has the client tried in dealing with the problem? Elaborate as much as necessary to clarify the history
   and extent of the presenting problem. Are there themes in the history (either in what the client has
   experienced, or in their typical coping responses, or relationships with others?

III. Relevant Background Information:
   Family history, marital history, educational and work history, military service. Include nature of pertinent
   relationships. List any history of difficulties (personal/family mental-health history, substance abuse
   history).

IV. Psychosocial Adjustment / Strengths and Resources:
   Nature and quality of social networks. Does the client have access to social support at work, home,
   neighborhood, church, and other sources? Where in life does the client feel competent and
   successful? Identify the client’s skills, strengths, and resources that may prove helpful with their current
   problem.

V. Case Conceptualization:
   Conceptualizing a case includes using a theoretical and pragmatic framework to make sense of
   (explain) a client’s situation (their presenting concerns, signs, and symptoms), in order to plan your
   counseling services. What you write here should succinctly summarize that process. Although you will
   be sharing your professional opinion, it should be rational, consistent, and supported by data. Begin by
   briefly summarizing the most relevant data gathered in your assessment (information on this page, any
   information checked present on the MSE checklist, ASI/ASAM information, and any other assessment
   tools or procedures used). This should include presenting concerns, signs, symptoms, relevant past
   significant events, relevant medical conditions, relevant current stressors and overall level of
   functioning, including how his/her customary coping strategies affect his/her capacity to deal with the
   problem, as well as your perception of the degree of severity of the client’s concerns, supported by the
   data you have summarized. You may describe how the client makes sense of their presenting
   concerns, and how his/her customary coping strategies affect his/her capacity to deal with the problem.
   This should be a short paragraph that concisely and clearly explains what is going on with the client.

DSM Diagnosis: You must include a full 5-axis diagnosis here for all clients. If you need to later adjust
the diagnosis as you come to better understand your client, you must clearly indicate this and enter the
new diagnosis (include all 5 axes again) on the Client Progress section of a Session Note.

VI. Initial Treatment Plan:
   Briefly describe your initial plans for treatment. This should be clearly connected to the case
   conceptualization, and will include counseling objectives (focus of treatment), and counseling approach
   (means that will be used to achieve the objectives – theoretical orientation, specific treatment
   techniques). Also note modality of services (individual, conjoint, family, group, play), frequency of
   sessions, and estimated duration of treatment.

Revised 2012 . 08
Session Note

Client Name: Click here to enter text. Service Date: Click here to enter a date.

Counselor Name: Click here to enter text. Session #: Click here to enter text.

Subjective:
Click here to enter text.

Objective:
Click here to enter text.

Assessment:
Click here to enter text.

Plan:
Click here to enter text.

Next Session: Click here to enter a date.

Counselor Signature Date Supervisor Signature Date
Session Note – Play Therapy

Client Name:  Click here to enter text.  Service Date:  Click here to enter a date.

Client’s Age:  Click here to enter text.

Counselor Name:  Click here to enter text.  Session #:  Click here to enter text.

Client’s Predominant Emotions:  (Indicate all displayed, how communicated, and client awareness)
  Click here to enter text.

Session Summary:  (Brief description of play behaviors & toys, play sequence, significant play breaks, significant verbalizations)
  Click here to enter text.

Limits Set (check all that apply and add a brief explanation):
  ☐ Safety (client / counselor):  Click here to enter text.
  ☐ Protect Property (room, toys):  Click here to enter text.
  ☐ Structuring:  Click here to enter text.

Clinical Impressions / Understanding:  (Conceptualization, progress on goals)
  Click here to enter text.

Play Themes (check all that apply):
  ☐ Exploratory  ☐ Relationship
  ☐ Power / Control  ☐ Nurturing
  ☐ Dependency  ☐ Grief & Loss
  ☐ Revenge  ☐ Abandonment
  ☐ Safety / Security  ☐ Protection
  ☐ Mastery  ☐ Separation
  ☐ Helpless  ☐ Reparation
  ☐ Resiliency  ☐ Chaos / Instability
  ☐ Hopeless  ☐ Perfectionism
  ☐ Powerless  ☐ Anxiety
  ☐ Other:  Click here to enter text.

Plan / Recommendations:
  Click here to enter text.

Next Session:  Click here to enter a date.

Counselor Signature  Date  Supervisor Signature  Date
Group Session Note

Service Date: Click here to enter a date.

Clients Present: Click here to enter text.

Counselor Name(s): Click here to enter text.  

Observations of Group Process:

Click here to enter text.

Plan:

Click here to enter text.

Next Session: Click here to enter a date.

Counselor Signature  Date  Supervisor Signature  Date
Outcome Rating Scale (ORS)

<table>
<thead>
<tr>
<th>Name: ____________________________</th>
<th>Age (yrs): _______</th>
<th>Gender: ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session # _________</td>
<td>Today’s Date ____________________________</td>
<td></td>
</tr>
</tbody>
</table>

Who is filling out this form? Please check one:
- Self □
- Other □

If other, what is your relationship to this person?

<table>
<thead>
<tr>
<th>Individually</th>
<th>Interpersonally</th>
<th>Socially</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Personal well-being)</td>
<td>(Family, close relationships)</td>
<td>(Work, school, friendships)</td>
<td>(General sense of well-being)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

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Child Outcome Rating Scale (CORS)

Name: ___________________________ Age (yrs): ________ Gender: _________
Session # ___________ Today’s Date __________________________
Who is filling out this form? Please check one: Child □ Caretaker □
If caretaker, what is your relationship to this child? __________________________

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. If you are a caretaker filling out this form, please fill out according to how you think the child is doing.

Me
(How am I doing?)

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>😊</td>
</tr>
</tbody>
</table>

Family
(How are things in my family?)

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>😊</td>
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</tbody>
</table>

School
(How am I doing at school?)

<table>
<thead>
<tr>
<th></th>
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<td>😊</td>
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</table>

Everything
(How is everything going?)

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>😊</td>
</tr>
</tbody>
</table>

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Young Child Outcome Rating Scale (YCORS)

Name: ___________________________ Age (yrs): _______ Gender: _______

Session # ___________  Today’s Date ________________________________

Who is filling out this form? Please check one:

Child ☐  Caretaker ☐

If caretaker, what is your relationship to this child?

______________________________________________________________

Choose one of the faces that shows how things are going for you. Or, you can draw one below that is just right for you.

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Please rate today’s session by placing a mark on the line nearest to the description that best fits your experience.

**Relationship**

I did not feel heard, understood, and respected. | I felt heard, understood, and respected.

**Goals and Topics**

We did not work on or talk about what I wanted to work on and talk about. | We worked on and talked about what I wanted to work on and talk about.

**Approach or Method**

The therapist’s approach is not a good fit for me. | The therapist’s approach is a good fit for me.

**Overall**

There was something missing in the session today. | Overall, today’s session was right for me.

---

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Only
How was our time together today? Please put a mark on the lines below to let us know how you feel.

**Listening**

- did not always listen to me. [_face emoji]
- listened to me. [_face emoji]

**How Important**

- What we did and talked about was not really that important to me. [_face emoji]
- What we did and talked about were important to me. [_face emoji]

**What We Did**

- I did not like what we did today. [_face emoji]
- I liked what we did today. [_face emoji]

**Overall**

- I wish we could do something different. [_face emoji]
- I hope we do the same kind of things next time. [_face emoji]

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Young Child Session Rating Scale (YCSRS)

Name: ___________________________ Age (yrs): _______ Gender: _______

Session # ________ Today’s Date ____________________________

Who is filling out this form? Please check one:
   Child □   Caretaker □

If caretaker, what is your relationship to this child?
   ____________________________________________

Choose one of the faces that shows how it was for you to be here today. Or, you can draw one below that is just right for you.

[Diagrams of four faces: happy, sad, neutral, and angry faces]
Group Session Rating Scale (GSRS)

Name: ____________________________  Age (yrs): _______  Gender: _______
Session # ___________  Today’s Date __________________________

Please rate today’s group by placing a mark on the line nearest to the description that best fits your experience.

**Relationship**

I did not feel understood, respected, and/or accepted by the leader and/or the group. ____________________________

I felt understood, respected, and accepted by the leader and the group. ____________________________

**Goals and Topics**

We did not work on or talk about what I wanted to work on and talk about. ____________________________

We worked on and talked about what I wanted to work on and talk about. ____________________________

**Approach or Method**

The leader and/or the group’s approach is not a good fit for me. ____________________________

The leader and group’s approach is a good fit for me. ____________________________

**Overall**

There was something missing in group today – I did not feel like a part of the group. ____________________________

Overall, today’s group was right for me – I felt like a part of the group. ____________________________

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Leeds Alliance in Supervision Scale (LASS)

Supervisee: ______________________  Supervisor: ______________________
Session # ________  Date of supervision session ______________________

Please place a mark on the lines to indicate how you feel about your supervision session

---

### Approach

This supervision session was not focused  [--------------------]  This supervision session was focused

### Relationship

My supervisor and I did not understand each other in this session  [--------------------]  My supervisor and I understood each other in this session

### Meeting My Needs

This supervision session was not helpful to me  [--------------------]  This supervision session was helpful to me

---

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Only
Contact Note

Client Name:  ____________________________  Contact Date:  ____________________________

Contact with:  ____________________________

Relationship to Client:  ____________________________

Summary of Contact:

______________________________  ____________________________

Counselor Signature  Date  Supervisor Signature  Date
Counselor Education Training Clinic

C. E. T. C.
Helping Individuals, Couples, and Families to Thrive

Counseling Service-Plan

Client Name: ___________________________ Date of Birth: ________________

Counselor Name: ________________________ Date: ________________________

☐ Initial Service Plan  ☐ Service Plan Review

Client Strengths / Resources: ____________________________________________

Case Management Needs & Plans: _________________________________________

Counseling Service Goals: Note whether goals are new or ongoing. If this is a Service-Plan Review, indicate progress toward goal achievement since the last review (where 1 = little progress, 2 = some progress, 3 = much progress), and note whether goal will remain a clinical goal for the next 30 days. Write "N/A" in any blank space.

1. Desired Outcome:
   - ☐ New  ☐ Ongoing
   - If ongoing, progress since last review: _____ Remain? ☐ Yes  ☐ No
   - Achievement Criteria: _____________________________________________

2. Desired Outcome:
   - ☐ New  ☐ Ongoing
   - If ongoing, progress since last review: _____ Remain? ☐ Yes  ☐ No
   - Achievement Criteria: _____________________________________________

3. Desired Outcome:
   - ☐ New  ☐ Ongoing
   - If ongoing, progress since last review: _____ Remain? ☐ Yes  ☐ No
   - Achievement Criteria: _____________________________________________

Clinical Plans: Mode (check one):  ☐ Individual  ☐ Couple  ☐ Family  ☐ Group

Planned Frequency: ___________________ Activities: ___________________

► Next Review Date (no more than 30 days from today’s date): ___________________

Client Signature ___________________ Date ________________

Counselor Signature _______________ Date _______________ Supervisor Signature _______________ Date _______________
Closing / Transfer Summary

☐ Closing  ☐ Transfer To:  Click here to enter text.

Client Name:  Click here to enter text.  Date of Birth:  Click here to enter text.
Counselor:  Click here to enter text.  Date:  Click here to enter a date.

Service Summary:

First Appointment:  Click here to enter a date.  Individual Sessions:  Click here to enter text.
Last Appointment:  Click here to enter a date.  Couple/Family Sessions:  Click here to enter text.
Cancellations  Click here to enter text.  Group Sessions:  Click here to enter text.
No-Show  Click here to enter text.  Total Sessions Attended:  Click here to enter text.

Initial Presenting Concerns:  Click here to enter text.

Service Goals:  Click here to enter text.

Progress on Goals:  Click here to enter text.

Factors Enhancing Positive Outcomes:  Click here to enter text.

Barriers to Positive Outcomes:  Click here to enter text.

Reason for Service Termination:  Click here to enter text.

Ongoing Concerns / Future Recommendations:  Click here to enter text.

Counselor Signature  Date  Supervisor Signature  Date
Client Feedback Form

Your Name: ___________________________ Date: ______________

Your Counselor’s Name: ___________________________

The purpose of this short set of questions is to provide your counselor with additional feedback for continued professional development. Your perspective is very important. *Please be as honest as you can.*

What did you find helpful about your counselor?

How could your counselor have been more helpful to you (in how they behaved or things they did)?

On a scale from 1 to 10 (1 = poor, and 10 = excellent) how would you rate your counselor, and why?

1 2 3 4 5 6 7 8 9 10

What would you change about your counseling experience?

Please Draw an "X" on the line nearest to the description that best fits your experience with counseling:

I did not feel heard, understood and respected

We did not work on or talk about what I wanted to work on and talk about

The counselor’s approach was not a good fit for me

I felt heard, understood and respected

We worked on and talked about what I wanted to work on and talk about

The counselor’s approach was a good fit for me.

Thank you for your time
Consent to Bi-Lateral Release of Information

Client Name: ________________________________  Date of Birth: ________________

Counselor Name: ________________________________  Date: ________________

I hereby request and authorize the Counselor Education Training Clinic (CETC) and

Name of Professional  Title  Name of Organization

Specify the name of the person & organization with whom the C.E.T.C. will be sharing information

Mailing Address

City  State  Zip Code  Phone Number

CETC to exchange information about me in compliance with 42 CFR Part 2 and 45 CFR parts 160 and 164. Information may be exchanged with respect to any illness, medical history, consultation, evaluation, counseling / psychotherapy, school performance, drug or alcohol abuse, and behavior during the period from initial contact to the last date of contact. I understand that I may request in writing that specific portions of my records not be released or referred to in the course of taking action upon this request.

Counselor: specify the exact information to be released and state the exact purpose for the release:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I understand that I may refuse to consent to this release without penalty and / or without being refused services. I also understand that I may withdraw this consent at any time except to the extent that action has already been taken in reliance thereon. This authorization will expire (check one):

☐ Upon completion or fulfillment of the above stated purposes
☐ On ______ / ______ / ______ (may not be more than one year from today’s date)

► I have read this consent; it has been explained to me, and all blanks were filled in prior to my signing this form. I understand that I am giving permission for information about me to be shared as noted above, and I do voluntarily give my consent thereto.

Client Signature (Guardian if minor)  Date

Counselor Signature  Date  Supervisor Signature  Date
Consent to Bi-Lateral Release of Information – Lab School

Child's Name: ___________________________ Date of Birth: ____________

Counselor Name: _________________________ Date: ________________

I hereby request and authorize the Counselor Education Training Clinic (CETC) and

**UW Lab School (Counselor, Teachers, Administrators)**

Specify the person & organization with whom the CETC will be sharing information

**Education Bldg. # 132; University of Wyoming**

<table>
<thead>
<tr>
<th>Mailing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laramie, WY, 82071 (307) 721-2155</td>
</tr>
</tbody>
</table>

City State Zip Code Phone Number

...to exchange information about my child in compliance with 42 CFR Part 2 and 45 CFR parts 160 and 164. Information may be exchanged with respect to any illness, medical history, consultation, evaluation, counseling / psychotherapy, school performance, drug or alcohol abuse, and behavior during the period from initial contact to the last date of contact. I understand that I may request in writing that specific portions of my child's records not be released or referred to in the course of taking action upon this request.

Unless you specify otherwise in writing, this release allows your child's counselor at the CETC and the counselor, administrators, teachers and other Lab School professionals to communicate with each other about your child's services, performance, and progress (in counseling and in school). Information will only be shared as deemed pertinent and necessary to help professionals at the CETC and the school better serve your child.

I understand that I may refuse to consent to this release without penalty and / or without being refused any service. I also understand that I may withdraw this consent at any time except to the extent that information has already been shared. This authorization will expire (check one):

- □ Upon termination of services through the CETC
- □ On _______ / _______ / _______ (may not be more than one year from today's date)

► I have read this consent; it has been explained to me, and all blanks were filled in prior to my signing this form. I understand that I am giving permission for information about my child to be shared as noted above, and I do voluntarily give my consent thereto.

Client Signature (Guardian if minor) Date

Counselor Signature Date Supervisor Signature Date
Information about Substance Use Assessments

Our Program hopes to assist you with the completion of your substance use assessment and provide follow-up recommendations. The process usually involves three or more sessions during which we will work with you to find out what happened, hear your story and then if needed, we will complete with you a fairly structured questionnaire that may be required by the person or agency that referred you for this evaluation.

Sometimes substance use or overuse is a situational event (personal celebrating, peer influence, phase of life, experimentation) and sometimes it is related to a more serious problem that begins to negatively affect other areas of your life such as your health, employment, grades, relationships, and mental focus. What we will do is to try to see how this event got you here, how it is influencing your life, and how other areas of your life may be influencing your substance use. What we hope is that you might see something or learn something in a way that can reduce the likelihood that you will have a problem with substance use or abuse.

You may discover that you do not have a problem with overuse and that you just need to get the evaluation completed. Most likely, you are concerned about the consequences of this event and you really want to take care of all of the responsibilities. You may decide there could be a problem and you might want to get some support for making positive changes.

The Addiction Severity Index (ASI)

The ASI is a structured interview/questionnaire required by the state to assist determining if an individual is experiencing a problematic level of substance use or overuse. The interview takes a comprehensive look at six areas of your life to see how your life and substance use are influencing each other, and to understand if either is becoming a problem. The six areas include medical/health; employment/school; alcohol and drug use; legal challenges; family and social relationships and psychological/emotional concerns, if any. From this evaluation you can create a plan of action to help you make sure that alcohol and drug use do not cause you problems. Your plan might include a variety of options such as attending individual counseling sessions, completing a substance abuse educational class, attending more intensive counseling support services, involving yourself with community support systems, and other self-care options. Substance use may be causing you more harm than you realized and we would like to support your well being. We also can send a recommendation plan to the referring agency. We will need a Consent to Bi-Lateral Release of Information form signed by you which gives us legal permission to send any information to any persons outside of this clinic.

ASI Evaluation Feedback and ASAM Placement Criteria Summary

The ASI provides feedback about the six areas of your life and helps us identify the level of challenge you are facing in each of the six areas. You and your counselor will review the findings and design your plan, including recommendations being sent to your referring agency if needed. The American Society of Addictions Medicine (ASAM) Placement Criteria Summary form is a checklist that can be used to determine the level of treatment that you may be recommended to follow. The levels range from no treatment to inpatient. Some referring agencies may request an ASAM checklist. We can provide that if needed.
## Clinical Interview – Addiction Severity Index

**Client Name:** ________________________________  **Date of Birth:** ________________

**Counselor Name:** ________________________________  **Today’s Date:** ________________

**Local Address:** ________________________________  **Phone #:** ________________________________

- How long have you been at this address? ____________  Do you / your family own this address? _______

**Of what race do you consider yourself?** ________________________________

**What is your preferred religion or faith tradition?** ________________________________

**Have you been in a controlled environment in the past 30 days?** (indicate type and length of stay, or write "no"): ________________________________

### Referral

**Who referred you for an evaluation?**  **Name:** ________________________________  **Position:** ________________________________

**Address:** ________________________________  **Phone #:** ________________________________

**Were you ordered to receive an assessment?** (Y / N) ________  **B.A.C.** (if applicable): ________________________________

- **Who ordered it?** (Judge, Probation Officer, Parole Board, Presentence, Other (specify)

**Why are you receiving this assessment?** (Arrest – OWI/DUI, Court Order, Attorney Recommendation, Self-Interest, other)

- ________________________________

**Comments:** ________________________________

### Medical Status

**How many times in your life have you been hospitalized for medical problems (include and overdoses, delirium tremens, exclude detox).**

**How long ago was your last hospitalization for a physical problem?** ________ years, ________ months

- **What was it for?** ________________________________

**Do you have any chronic medical problems that continue to interfere with your life?** (Y / N) ________

- **Specify:** ________________________________

**Are you taking any prescribed medication on a regular basis?** (Y / N) ________

- **Specify:** ________________________________

- **What is it for?**
Do you receive financial compensation (pension, disability, etc.) for a physical disability? (Y / N) ________

Specify: ________________________________________________________________

How many days have you experienced medical problems in the past 30 days? ________

How troubled or bothered have you been by these medical problems in the past 30 days?
Not at all  Slightly  Moderately  Considerably  Extremely

How important to you now is treatment for these medical problems?
Not at all  Slightly  Moderately  Considerably  Extremely

Counselor:

How would you rate the client's current need for medical treatment? ________

0 = None  Needed to 9 = immediate treatment needed to intervene in a life-threatening situation

Is this medical status information significantly distorted by:

Client's misrepresentation? (Y / N) ________

Client's inability to understand? (Y / N) ________

Comments: ________________________________________________________________

Employment / Support Status

Last year of schooling completed (GED = 12th grade): ________________________________

Training or technical education completed: ________________________________

Do you have a valid driver's license? (Y / N) ________

Do you have access to an automobile? (Y / N) Answer "No" if no valid driver's license

How long was your longest full-time job? ________ Years, ________ months

Usual (or last) occupation (brief description) ____________________________________________

Does someone contribute to your support in any way? (Y / N) ________

Specify all: __________________________________________________________________

Does this constitute the majority of your support? (Y / N) ________

Current Employment Status: __________________________________________________________

Full time (35+ hrs / week)  Part-time Regular  Part-Time Irregular  Student

Unpaid Volunteer  Retired / Disability  Unemployed  In Controlled Environment

How many days were you paid for working in the last 30 days? ________

How much money did you receive from the following sources in the past 30 days?

Employment (take-home income) $__________  Unemployment Compensation $__________

Welfare $__________  Pension or Social Security $__________

Spouse, Family or Friends $__________  Illegal Activities $__________

What was your total income last year? $__________

How many people depend on you for the majority of their food, shelter, and support? ________

How many days have you experienced employment problems in the past 30 days? ________

How troubled or bothered have you been by these employment problems in the past 30 days?
Not at all  Slightly  Moderately  Considerably  Extremely
How important to you now is counseling for these employment problems?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Considerably</th>
<th>Extremely</th>
</tr>
</thead>
</table>

**Counselor:**

How would you rate the client's need for employment counseling? ______

0 = None Needed to 9 = immediate treatment needed to intervene in a life-threatening situation

Is this employment / support status information significantly distorted by

Client's misrepresentation (Y / N) ______

Client's inability to understand (Y / N) ______

**Comments:** ____________________________________________________________

**Drug / Alcohol Use**

What age did you first try alcohol or drugs? ______ What was it? ________________________________

Ask the client to indicate their frequency of use for the following substances / time-frames / methods:

<table>
<thead>
<tr>
<th>Substance</th>
<th>Past 30 days</th>
<th>Lifetime</th>
<th>Method (oral, nasal, smoking, Injection, IV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol – any use at all</td>
<td>_______</td>
<td>_______</td>
<td>____________________________</td>
</tr>
<tr>
<td>Alcohol – to Intoxication</td>
<td>_______</td>
<td>_______</td>
<td>____________________________</td>
</tr>
<tr>
<td>Heroin</td>
<td>_______</td>
<td>_______</td>
<td>____________________________</td>
</tr>
<tr>
<td>Methadone</td>
<td>_______</td>
<td>_______</td>
<td>____________________________</td>
</tr>
<tr>
<td>Other opiates or analgesics</td>
<td>_______</td>
<td>_______</td>
<td>____________________________</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>_______</td>
<td>_______</td>
<td>____________________________</td>
</tr>
<tr>
<td>Other sed / hyp / tranq</td>
<td>_______</td>
<td>_______</td>
<td>____________________________</td>
</tr>
<tr>
<td>Cocaine</td>
<td>_______</td>
<td>_______</td>
<td>____________________________</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>_______</td>
<td>_______</td>
<td>____________________________</td>
</tr>
<tr>
<td>Cannabis (Marijuana)</td>
<td>_______</td>
<td>_______</td>
<td>____________________________</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>_______</td>
<td>_______</td>
<td>____________________________</td>
</tr>
<tr>
<td>Inhalants</td>
<td>_______</td>
<td>_______</td>
<td>____________________________</td>
</tr>
<tr>
<td>More than one per day</td>
<td>_______</td>
<td>_______</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

Have you ever used a needle to administer any of these drugs? (Y / N) ______

Are you an IV drug user? (Y / N) ______

**Counselor:**

Which of the substance(s) above do you (the counselor) consider to be the major problem? (list all that apply)

How long was your last voluntary abstinence from this major substance (counselor identified)? ________ months

How many months ago did this abstinence end? ________ months ________ Still abstinent

How many times have you:

- Had alcohol delirium tremens? ________
- Overdosed on drugs? ________
- Been treated for alcohol abuse? ________ How many for detox only? ________
- Been treated for drug abuse? ________ How many for detox only? ________
How long ago were you last in treatment? ________ years ________ months

Name of center: ____________________________________________________________

Address: __________________________________________________________________

Type of treatment (inpatient / outpatient): ________________________________

How long did it last? ________ days Did you successfully complete it? (Y / N) ________

Have you ever been evaluated for alcohol or drug use before today? (Y / N) ________

When? __________________________ Where? _________________________________

How much money would you say you spent during the last 30 days on:

Alcohol? $ __________ Drugs? $ __________

How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days (including AA and NA meetings)? ________ days

How many days in the past 30 days have you experienced:

Alcohol problems? ________ Drug problems? ________

How troubled or bothered have you been in the past 30 days by alcohol problems?

Not at all Slightly Moderately Considerably Extremely

How troubled or bothered have you been in the past 30 days by drug problems?

Not at all Slightly Moderately Considerably Extremely

Counselor:

How would you rate the client's need for treatment for alcohol problems? ________ Drug problems? ________

0 = None Needed to 9 = immediate treatment needed to intervene in a life-threatening situation

Is this drug / alcohol status information significantly distorted by

Client's misrepresentation (Y / N) ________

Client's inability to understand (Y / N) ________

Comments: __________________________________________________________________

________________________

Legal Status

Are you currently on probation? (Y / N) ________ Parole? (Y / N) ________

How many times in your life have you been arrested and charged with the following: (list arrests / convictions)

- Vandalism? ________ / ________ Times Under the influence? (Y / N) ________
- Parole / probation violations? ________ / ________ Times Under the influence? (Y / N) ________
- Drug Charges? ________ / ________ Times Under the influence? (Y / N) ________
- Forgery? ________ / ________ Times Under the influence? (Y / N) ________
- Weapons offences? ________ / ________ Times Under the influence? (Y / N) ________
- Breaking & enter? ________ / ________ Times Under the influence? (Y / N) ________
- Stealing? ________ / ________ Times Under the influence? (Y / N) ________
- Assault? ________ / ________ Times Under the influence? (Y / N) ________
- Arson? ________ / ________ Times Under the influence? (Y / N) ________
- Rape / sex-related crimes? ________ / ________ Times Under the influence? (Y / N) ________
<table>
<thead>
<tr>
<th>Crime</th>
<th>Times</th>
<th>Under the influence? (Y / N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicide / manslaughter?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostitution?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contempt of court?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disorderly conduct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vagrancy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public intoxication?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driving while intoxicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor in possession (MIP)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major driving violations?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How many months were you incarcerated in your life? ________ months
How long was your last incarceration? ________ months
What was it for? ______________________________________
Are you presently awaiting charges, trial or sentencing? (Y / N) ________ Which? ______________________________________
For what? __________________________________________________
How many days in the past 30 days were you detained or incarcerated? ________
How many days in the past 30 days have you engaged in illegal activities for profit? ________
How serious do you feel your present legal problems are (criminal only – exclude civil problems)?
Not at all  | Slightly  | Moderately  | Considerably  | Extremely
How important to you now is counseling or referral for these legal problems?
Not at all  | Slightly  | Moderately  | Considerably  | Extremely

Counselor:
How would you rate the client's current need for legal services or counseling? ________
0 = None Needed to 9 = immediate treatment needed to intervene in a life-threatening situation
Is this legal status information significantly distorted by:
Client's misrepresentation? (Y / N) ________
Client's inability to understand? (Y / N)
Comments: __________________________________________________

Family History / Social Relationships
Marital Status (co-living, married, remarried, widowed, separated, divorced, never married): ______________________
How long have you held this status (if never married, time since age 18)? ________ years ________ months
Are you satisfied with this situation? (Y / N / indifferent) ________
How many children do you have? ________ With how many different partners?
Usual living arrangement for the past 3 years (with sexual partner and children, with sexual partner alone, with children alone, with parents, with other family, with friends, alone, controlled environment, no stable arrangements)
____________________________
How long have you lived in these arrangements? (if with family or parents, since age 18) ________
Are you satisfied with these arrangements (Y / N / indifferent) ________
Do you live with anyone who:

- Has a current alcohol problem? (Y / N)
- Uses non-prescribed drugs? (Y / N)

With whom do you spend most of your free time? (family, friends, alone)
- Are you satisfied spending your free time this way (Y / N / indifferent)
- How many close friends do you have?

Would you say you have had close relationships with any of the following people in your life? (Y / N / NA / No Answer)

- Mother -
- Father -
- Brothers / Sisters -
- Spouse / Sexual Partner -
- Children -
- Friends -

Have you had significant periods in which you experienced serious problems getting along with: (Y / N / NA / No Answer)

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Past 30 days</th>
<th>Lifetime</th>
<th>Affected by alcohol or drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers / Sisters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse / Sexual Partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Close friends</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighbors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coworkers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Did any of these people abuse you? (note who, none, or yes but denied to identify)

<table>
<thead>
<tr>
<th></th>
<th>Past 30 days</th>
<th>Lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotionally (made you feel bad)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physically (caused you physical harm)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually (forced sexual activity)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have any of your relatives had what you would call significant drinking, drug use, or psychological problems—that either did or should have led to treatment? (Y / N / NA / No Answer)

<table>
<thead>
<tr>
<th>Person</th>
<th>Alcohol</th>
<th>Drug</th>
<th>Psychological (note type)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother's father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother's sister / brother (circle)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father's mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father's father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father's sister / brother (circle)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your brother(s) if Y, indicate # / total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your sisters(s) if Y, indicate # / total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Counselor: Draw a simple 3-generation genogram in the space below

How many days in the past 30 days have you experienced serious conflicts:

<table>
<thead>
<tr>
<th></th>
<th>With family</th>
<th>With others (excluding family)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How troubled or bothered have you been by these conflicts in the past 30 days?

<table>
<thead>
<tr>
<th></th>
<th>With Family</th>
<th>With others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Slightly</td>
<td>Moderately</td>
</tr>
<tr>
<td></td>
<td>Considerably</td>
<td>Extremely</td>
</tr>
</tbody>
</table>

How important to you now is counseling or treatment for these problems?

<table>
<thead>
<tr>
<th></th>
<th>With Family</th>
<th>With others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Slightly</td>
<td>Moderately</td>
</tr>
<tr>
<td></td>
<td>Considerably</td>
<td>Extremely</td>
</tr>
</tbody>
</table>

Counselor:

How would you rate the client’s need for family and or social relationship counseling? __________

0 = None Needed to 9 = immediate treatment needed to intervene in a life-threatening situation

Is this family / social relationships information significantly distorted by

Client’s misrepresentation (Y / N) __________

Client’s inability to understand (Y / N)

Comments: ___________________________________________________________

__________________________________________________________

Psychological / Emotional Status

How many times in your life have you been treated for any psychological or emotional problems:

In a hospital or inpatient setting? __________ In an outpatient or private setting? __________

Do you receive financial compensation for a psychiatric or emotional disability? (Y / N) __________

SSI, SSDI, pension

Have you had a significant time period (not a direct result of drug/alcohol use) in which you have experienced: (Y / N)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Past 30 days</th>
<th>Lifetime</th>
<th>Under Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious depression – sadness, hopelessness, loss of interest, difficulty</td>
<td>__________</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>with daily functioning?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious anxiety/tension – uptight, unreasonably worried, unable to feel</td>
<td>__________</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>relaxed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallucinations – say things or heard voices that others did not see or</td>
<td>__________</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>hear?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble understanding, concentrating, or remembering?</td>
<td>__________</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>Trouble controlling violent behavior including having episodes of rage or</td>
<td>__________</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>violence?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Past 30 days</td>
<td>Lifetime</td>
<td>Under Influence</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------</td>
<td>----------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Serious thoughts of suicide?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attempted suicide?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Been prescribed medication for psychological or emotional problems?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How many days in the past 30 days have you experienced these psychological or emotional problems?  

How much have you been troubled or bothered by these problems in the past 30 days?  

Not at all  
Slightly  
Moderately  
Considerably  
Extremely  

How important to you now is treatment for these psychological or emotional problems?  

Not at all  
Slightly  
Moderately  
Considerably  
Extremely  

Counselor:

At the time of this interview, is the client:

Obviously depressed / withdrawn? (Y / N)  
Obviously hostile? (Y / N)  
Obviously anxious / nervous? (Y / N)  
Having trouble with reality testing, thought disorders, paranoid thinking? (Y / N)  
Having trouble comprehending, concentrating, and remembering? (Y / N)  
Having suicidal thoughts? (Y / N)  

How would you rate the client's current need for psychological / psychiatric treatment?  

0 = None Needed to 9 = immediate treatment needed to intervene in a life-threatening situation  

Is this psychological / emotional status information significantly distorted by:

Client's misrepresentation? (Y / N)  
Client's inability to understand? (Y / N)  

Comments:  

______________________________  

Overall Severity Profile:

Counselor

Copy the information you indicated in each section above regarding the severity of the client's problems:

0 = None Needed to 9 = immediate treatment needed to intervene in a life-threatening situation  

Medical  
Alcohol  
Legal  
Psychological / Emotional  

Employment / Support  
Drug  
Family / Social  

______________________________  

Counselor Signature  
Date  

______________________________  

Supervisor Signature  
Date
American Society of Addictions Medicine (ASAM) Placement Criteria Decision Summary

Client Name:  Click here to enter text.  Date of Birth:  Click here to enter text.
Counselor Name:  Click here to enter text.  Today's Date:  Click here to enter a date.

► Use these guidelines with clinical judgment about each client's unique circumstances and needs.

Dimension 1: Detox / Withdrawal Symptoms

Check all that apply:
- seizures
- sweats
- fever
- loss of coordination
- cravings
- nausea
- delirium tremens (DT's)
- headache

Level 0 – Stable – No treatment recommendations
Level 0.5 – Educational Intervention – Does not meet treatment criteria
Level I – Outpatient Treatment (Must meet one of the following):
- Minimum or no risk of withdrawal
- Withdrawal symptoms with minimal risk of severe withdrawal syndrome
- Adequate support services available to complete detoxification and treatment

Level II – Intensive Outpatient (Must meet one of the following):
- Minimum or no risk of withdrawal
- If exhibiting withdrawal symptoms, there is medical clearance. Patient and support persons understand withdrawal care instructions
- Adequate support services available to complete detoxification and treatment

Level III – Residential (Must meet one of the following):
- Risk or presence of withdrawal noted, manageable in this setting with medical clearance
- Previous history of non-entry into treatment following detoxification
- Continued use of non-prescribed mind-altering substances during detoxification at a less intensive level of care

Level IV – Medically Managed Inpatient (must meet one of the following):
- Risk or presence of severe withdrawal syndrome
- Detoxification during pregnancy

Dimension 2: Biomedical Conditions and Complications

Check all that apply:
- persistent Cough
- heart disease
- epilepsy
- stomach problems
- diabetes
- kidney disease
- infectious disease (STD)
- chronic diseases
- seizures
- cancer
- liver disease
- tuberculosis
- high/low blood pressure
- problem pregnancies
- hepatitis
- other

Level 0 – Stable – No treatment recommendations
Level 0.5 – Educational Intervention – Does not meet treatment criteria
Level I – Outpatient Treatment (Must meet one of the following):
- Any physical health conditions are sufficiently stable to permit participation in treatment
- Physical health conditions require ongoing care which can be provided in coordination with the outpatient program
Level II – Intensive Outpatient (Must meet one of the following):
- Any physical health conditions are sufficiently stable to permit participation in treatment.
- Physical health conditions require ongoing care which can be provided in coordination with the outpatient program

Level III – Residential (Must meet one of the following):
- Risk or presence of withdrawal noted, manageable in this setting with medical clearance
- Previous history of non-entry into treatment following detoxification
- Continued use of non-prescribed mind-altering substances during detoxification at a less intensive level of care
- Risk of any alcohol/other drug use places the patient in imminent danger of serious damage to the physical health due to pre-existing conditions

Level IV – Medically Managed Inpatient (must meet one of the following):
- Physical complication of addiction requiring medical management
- Physical illness or pregnancy needing stabilization requiring medical management

Dimension 3: Emotional / Behavioral Stability
Level Met: Choose an item. Check all that apply:
- low self-esteem
- mental confusion
- delusions
- other
- trouble concentrating
- grief issues
- serious depression
- other
- violence / rage
- abandonment issues
- suicidal ideation
- other
- intense fear
- anxiety
- hallucinations

Level 0 – Stable – No treatment recommendations
Level 0.5 – Educational Intervention – Does not meet treatment criteria

Level I – Outpatient Treatment (Must meet one of the following):
- Emotional/behavioral conditions are mild enough to not interfere with treatment
- Coexisting emotional/behavioral conditions being addressed by appropriate additional services
- Any physical health conditions are sufficiently stable to permit participation in treatment
- Able to maintain emotional/behavioral stability in order to respond to treatment program
- Not at risk of harm to self or others (includes the fetus)

Level II – Intensive Outpatient (Must meet one of the following):
- Emotional/behavioral conditions are mild enough to not interfere with treatment
- Lacks ability to maintain emotional/behavioral stability over a 72-hour period
- Risk of further abuse/neglect of spouse/children, significant others (includes the fetus)
- Mild risk of endangering self or other (includes the fetus) [homicidal, suicidal thoughts, no plans]

Level III – Residential (Must meet one of the following):
- Co-existing emotional/behavioral conditions have complications requiring medical management
- Moderate risk of endangering self or other, increase in thoughts of homicide/suicide with non-lethal plans
- Stress reactions to recent/threatened losses prevent responding to treatment

Level IV – Medically Managed Inpatient (must meet one of the following):
- Co-existing emotional/behavioral conditions have complications requiring medical management
- Uncontrolled behavior endangering self or others (includes fetus), suicidal/homicidal thoughts and Lethal or attainable plans
- Mental confusion, fluctuating orientation, thought process impairment that is severe enough that client cannot care for self
- Alcohol/other drug use gravely complicates previously diagnosed psychiatric or emotional/behavioral condition

Dimension 4: Treatment Acceptance / Resistance
Level Met: Choose an item.
Level 0 – Stable – No treatment recommendations
Level 0.5 – Educational Intervention – Does not meet treatment criteria
Level I – Outpatient Treatment (Must meet both of the following):
- Agreement to cooperate and attend all scheduled activities
- Even with admission of an alcohol/other drug problem, monitoring and motivating strategies are needed

Level II – Intensive Outpatient (Must meet both of the following):
- Tendency to attribute alcohol/other drug problems to external events/people
- Agreement to participate; history of non-compliance of immediate lower level of care

Level III – Residential (Must meet the following):
- Non-acceptance or resistance to severity of the problem despite serious adverse consequences/effects on health, family, work or social life

Level IV – Medically Managed Inpatient (Admission to this level must meet Dimensions 1, 2 or 3)

Dimension 5: Relapse Potential
Level 0 – Stable – No treatment recommendations
Level 0.5 – Educational Intervention – Does not meet treatment criteria
Level I – Outpatient Treatment (Must meet the following):
- Scheduled therapeutic contacts are necessary to maintain recovery goals
Level II – Intensive Outpatient (Must meet one of the following):
- Inability to maintain recovery goals despite participation in a less intensive level of care
- Significantly lacks awareness of relapse potential, with much difficulty postponing gratification
Level III – Residential (Must meet one of the following):
- Acute crisis with imminent danger of continued substance use with severe consequences
- History of inability to reduce use of alcohol/other drugs, despite acknowledging severe consequences, and repeated attempts to do so
- The structure and related protocols to address relapse issues can only occur at this level
Level IV – Medically Managed Inpatient (Admission to this level must meet Dimensions 1, 2 or 3)

Dimension 6: Recovery Environment
Check all that apply:
- PO/DFS worker
- non-using family
- non-using friends
- fam/pers counseling
- safe living situation
- safe work place
- available transportation
- 12-step involvement
- 12-step sponsor
- other

Level 0 – Stable – No treatment recommendations
Level 0.5 – Educational Intervention – Does not meet treatment criteria
Level I – Outpatient Treatment (Must meet one of the following):
- A supportive environment exists for recovery
- Demonstrated motivation and willingness to change
Level II – Intensive Outpatient (Must meet the following):
- Professional interventions required for family/significant others and patient to improve chances of treatment success
- Ability to meet recovery goals unlikely in current work, family or social environment
Level III – Residential (Must meet one of the following):
- Removal from a volatile and/or non-supportive living environment is necessary to allow stabilization and recovery skill development
- Logistic impediments preclude accessing treatment at a lower level of care, e.g., distance, mobility, impairments, transportation
- Danger of physical, sexual or severe emotional victimization exists
- Risk to personal or public safety with continued alcohol/other drug use while engaged in occupation
Level IV – Medically Managed Inpatient (Admission to this level must meet Dimensions 1, 2 or 3)
Summary and Recommendations:

Possible Levels of Care:

0  Stable – No treatment recommendations
0.5 Early Intervention (Education / Support)
1.0 Outpatient (Counseling)
II.1 Intensive Outpatient
II.5 Partial Hospitalization
III.1 Clinically Managed Low Intensity Residential
III.3 Clinically Managed Medium Intensity Residential
III.5 Clinically Managed High Intensity Residential
III.7 Medically Monitored Intensive Inpatient Treatment
IV  Medically Managed Intensive Inpatient Services / Detox

Placement Criteria – Summary (select the appropriate level from each dimension above):

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Detox / Withdrawal</td>
<td>Choose an item.</td>
</tr>
<tr>
<td>2 – Physical Health</td>
<td>Choose an item.</td>
</tr>
<tr>
<td>3 – Emotional Condition</td>
<td>Choose an item.</td>
</tr>
<tr>
<td>4 – Treatment Acceptance</td>
<td>Choose an item.</td>
</tr>
<tr>
<td>5 – Relapse Potential</td>
<td>Choose an item.</td>
</tr>
<tr>
<td>6 – Recovery Environment</td>
<td>Choose an item.</td>
</tr>
</tbody>
</table>

Determination of Recommended Level of Care:

- Level 0 - No treatment recommendations
- Level 0.5 - No treatment need indicated; preventive education recommended
- Level I - Five of the six dimensions meet Level I criteria
- Level II - Dimensions 1, 2, & 3 are no greater than Level II, and Two of dimensions 4, 5, & 6 meet Level II criteria.
- Level III - Three of the six dimensions meet Level III criteria
- Level IV - One of dimensions 1, 2, or 3 meet Level IV criteria

Recommended Level of Care:  

Treatment Recommendations (Check all that apply):

- No follow-up services are recommended
- Referral to:  
- Individual Education / Support,  
- Groups: 
- Substance Abuse Education / DUI Classes
- Relapse Prevention Support
- Other:  
- Community Support Programs:  
- Frequency:  
- Duration:  

Client Signature ____________________________ Date ________________

Counselor Signature __________________________ Date ________________

Supervisor Signature _________________________ Date ________________

Revised 2012 . 08
Date:  

Judge  

Re:  

The Honorable Judge  

This letter is to confirm that  contacted the Counselor Education Training Clinic (CETC) to complete the Addiction Severity Index (ASI) and the ASAM Placement Criteria Summary. Below are the results of our interactions with this person, including our treatment recommendations.

Name of Client’s counselor:  

Client first contacted our office regarding services on  

Client signed a consent to release information on  

Client’s initial appointment was on:  

Number of sessions scheduled by client:  

Number of cancelled sessions:  

Number of scheduled sessions completed  

Client completed the ASI substance abuse evaluation on  

ASAM Level of Care recommended:  

Treatment Recommendations:  

- No follow-up services are recommended  
- Individual Counseling (number of sessions)  
- Groups:  
  - Substance Abuse Education / DUI Classes  
  - Relapse Prevention Support  
  - Other:  

Community Support Programs  

Follow-up appointment in  

Client successfully completed all recommendations for services on  

If necessary, we will keep you updated of 's progress through treatment. As always, feel free to contact us should you have additional questions.

Respectfully,

Counselor  

Clinic Coordinator
Client Safety Plan

► Counselor, fill out two copies of the form with your client by hand (one to client, one to file).

Client Name: ________________  Today’s Date: ________________

This plan is designed to help me keep myself and others around me safe. I know that life can be difficult sometimes, even for long periods of time. I also agree that life can get better, and this plan is to help me identify and plan to do things that will help me feel better.

When I have thoughts or feelings about hurting or killing myself, I will do the following things to help me feel better and stay safe: list the activity and frequency—if applicable.

1. ________________________________
2. ________________________________
3. ________________________________

When I have thoughts or feelings about hurting or killing myself, I will contact the following people: list name and phone number(s).

1. ________________________________
2. ________________________________
3. ________________________________

★ If at any time I don’t feel I can keep myself safe, even with the above activities and people, I agree that a brief hospital stay will be the best way to make sure that I stay safe long enough to start feeling better. I can go to the hospital myself, have a friend or loved one take me, or call the police (911) and they will help me get to the hospital.

I will review this plan next week with my counselor, and each week after, making any necessary additions or changes, until we both feel that it’s not necessary to continue reviewing it.

Client Signature  Date  Counselor Signature  Date
University of Wyoming – Professional Studies - Counseling
Counseling Student's Clinical Log

Student: ___________________________________  Instructor: __________________________
Site: _____________________________________  Supervisor: __________________________

Year: _______  Semester:  □ Fall  □ Spring  □ Summer
Course:  □ MS – Pre-Practicum  □ MS – Practicum  □ Internship
□ Doc-Practicum  □ Advanced Practicum  □ Child & Adolescent
□ Play Therapy  □ Other: _______________________

<table>
<thead>
<tr>
<th>Date / Week</th>
<th>Direct Client Contact</th>
<th>Supervision</th>
<th>Other Indirect (prep, notes, research)</th>
<th>Weekly Totals</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Individual / Triadic</td>
<td>Group: Site / Block</td>
<td>UW Class</td>
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Totals

Signatures:
Student
Date

Individual / Triadic Supervisor
Date

UW Course Instructor
Date

Revised 2010.08
Counseling Student:

Dates Enrolled in UW Counselor Education Program:

From: ____________ of ____________,  to: ____________ of ____________
(Month)  (Year)   (Month)  (Year)

<table>
<thead>
<tr>
<th>Semester, Year</th>
<th>Clinical Site or Course</th>
<th>Direct Client Contact</th>
<th>Individual / Triadic supervision</th>
<th>Group Supervision</th>
<th>Other Indirect Hours</th>
<th>Totals</th>
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Totals

Student Signature ___________________________  Date ____________

Counseling Program Faculty Signature ___________________________  Date ____________
Counseling Skills Evaluation Form
University of Wyoming, Department of Professional Studies, Counseling Program
Revised 2012

Student Name: ___________________________
Supervisor Name: ___________________________

Semester: □ Fall □ Spring □ Summer Year: ___________
Clinical Course: □ Pre-Prac □ Practicum □ Internship □ Doc-Prac □ Other: ___________

Instructions: Rate yourself / the Student on the items listed below by circling a letter for each category. The “no-information” category should be reserved for the rare cases where there really is no information at all. Remember to take into account the trainee’s developmental level in considering expectations (these expectations shift over the course of training). Both the trainee and supervisor should also write comments at each evaluation, identifying strengths and growth areas, plus plans for addressing those growth areas.

Use the following scale to rate yourself / the trainee according to expectations for his/her developmental level.
N = No Information; U = Unacceptable Performance; P = Progressing; M = Meets Expectations

Executive Skills:

1. **Therapeutic Relationship**: Appropriate pacing. Ability to communicate to the client unconditional positive regard, genuineness, congruence. Accurately communicates an empathic emotional response. Ability to establish and maintain a relationship of trust which will facilitate counseling progress.

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<tr>
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<tr>
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2. **Session Management**: Puts clients at ease. New clients: establish rapport, introduce the process of counseling, explain/obtain informed consent, set up the counseling contract. All clients: ability to flow in/out of clinical material at the beginning/end of the session, maintain appropriate focus on client concerns during the session.

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3. **Communication Skills**: Ability to reflect client content (paraphrasing—briefly restating content, summarizing—identifying patterns in clients’ statements, behaviors and experiences), reflect client feelings, and reflect meaning underlying client statements/patterns. Uses verbal and non-verbal encouragers, and effectively uses questions (open-ended, maximize client expression, limited use).

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4. **Intake**: Demonstrates skill in conducting an intake interview, a mental status evaluation, a biopsychosocial history, a mental health history, and a psychological assessment for treatment planning and caseload management. Screens for addiction, aggression, and danger to self and/or others, as well as co-occurring mental disorders.

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5. **Assessment**: Ability to clarify the client’s presenting problem (scope, dynamics, intensity, attempted solutions, client’s view of etiology). Recognition of the unique ecosystemic factors that may impact each client’s presenting problem and ability to resolve it. Ability to elicit client strengths and resources.

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6. **Diagnosis**: Demonstrates appropriate use of diagnostic tools, including the current edition of the DSM, to describe the symptoms and clinical presentation of clients with mental and emotional impairments. Is able to conceptualize an accurate multi-axial diagnosis of disorders presented by a client and discuss the differential diagnosis with collaborating professionals.

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</table>
7 **Treatment Planning & Execution:** Uses the principles and practices of diagnosis, treatment, referral, and prevention of mental and emotional disorders to initiate, maintain, and terminate counseling. Sets realistic, objective therapeutic goals and uses appropriate interventions. Applies effective strategies to promote client understanding of and access to a variety of community resources. Regularly evaluates client progress and appropriately adjusts goals and interventions.

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8 **Appropriate Use of Self:** Appropriate and effective use of immediacy (in-vivo discussion with client about the therapeutic relationship, the counselor’s feelings and reactions to the client), and self-disclosure. Willingness and ability to address difficult issues in session. Appropriately and effectively challenges clients.

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### Conceptual Skills:

9 **Knowledge-Base:** Has adequate understanding of counseling techniques, general client dynamics, information related to a variety of presenting problems, diagnostic criteria, potential interventions. Draws on knowledge-base to understand clients.

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10 **Theoretical Orientation:** Is developing a personal approach to counseling based on a sound rationale (rather than a hunt and peck approach), with sufficient flexibility to meet different client needs. Has sufficient understanding of other counseling theories to see how own approach interacts with them. Demonstrates consistency between theoretical orientation and counseling style.

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11 **Case Conceptualization:** Ability to make sense of client material. Can generate a variety of hypotheses about the etiology and possible resolution of clients’ concerns. Can develop and articulate a plan for addressing client concerns based on sound counseling principles, and which is consistent with the client’s worldview and the counselor’s theoretical orientation.

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### Professional Skills:

12 **Professional Conduct:** Professional dress; punctuality (start/end sessions on time, on time to supervision, class, etc.); follows policies and procedures; presents self as a professional to others; contributes meaningfully to the clinical team through observation and feedback of others’ sessions. Thoughtfully accepts other’s feedback. Communicates respect for the perspectives of others by actions. Resolves differences and conflict with colleagues in a professional, respectful manner.

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<td>Supervisor</td>
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13 **Ethical Practice:** Demonstrates the ability to apply and adhere to ethical and legal standards in clinical mental health counseling.

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<td>Supervisor</td>
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14 **Supervision:** Demonstrates the ability to recognize his or her own limitations as a clinical mental health counselor and to seek supervision or refer clients when appropriate. Makes good use of individual/triadic supervision (arrives on-time, prepared), and maintains regular contact with supervisors about all clients. Consults a supervisor in all safety/risk situations. Is open to supervisory feedback and trying new things. Provides appropriate feedback to supervisors.

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<td>Supervisor</td>
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15 **Documentation:** Applies current record-keeping standards related to clinical mental health counseling (all client documentation is on-time, clear, concise, and well organized. Reports, letters, and other documentation leaving the clinic are professional in style and make appropriate recommendations).

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</table>
16 **Multicultural Competence**: Applies multicultural competencies to clinical mental health counseling involving case conceptualization, diagnosis, treatment, referral, and prevention of mental and emotional disorders. Demonstrates appropriate use of culturally responsive individual, couple, family, group, and systems modalities for initiating, maintaining, and terminating counseling. Demonstrates the ability to modify counseling systems, theories, techniques, and interventions to make them culturally appropriate for diverse populations.

### Personal Management:

17 **Appropriate Boundaries**: Maintains appropriate personal and professional boundaries with clients and colleagues; does not use time with clients to meet own needs. Maintains appropriate boundaries in class and supervision.

18 **Self Awareness & Growth**: Recognizes own strengths and limitations. Understands impact of own values, experiences and biases on session dynamics and case conceptualization. Willing to continue exploring how self impacts clinical work. Willing to self-confront and grow. Is not defensive about feedback. Willing to seek help for personal awareness and growth when appropriate.

19 **Tolerance For Vulnerability and Risk**: Able to be appropriately vulnerable with clients and colleagues. Able to take risks with clients and colleagues. Is aware of and able to appropriately manage own affect in session, in class, and in supervision.

20 **Appropriate Self Care**: Recognizes own limits and physical, emotional and spiritual needs. Seeks healthy means for meeting own personal needs. Makes self-care and holistic personal wellness a reasonable priority, both in idea and action. Seeks help from others (including personal counseling) when appropriate.

### Mid-Term Comments

**Student:**

- **Strengths:**

- **Growth Areas:**

**Supervisor: **

- **Strengths:**

- **Growth Areas:**

---

**Student Signature**  **Date**  **Supervisor Signature**  **Date**
End-of-Term Comments

Student:
Strengths: ____________________________________________________________
__________________________________________________________
Growth Areas: __________________________________________________________
__________________________________________________________

Supervisor:
Strengths: ____________________________________________________________
__________________________________________________________
Growth Areas: __________________________________________________________
__________________________________________________________

Both - Specific plans (measurable) for the student's continued professional and personal growth:
Professional: 1 __________________________________________________________
2 __________________________________________________________
Personal 1 __________________________________________________________
2 __________________________________________________________

Student Signature ___________________________ Date ________________
Supervisor Signature ___________________________ Date ________________

Revised 2012.04
Counselor Evaluation of the Supervisor
For use in UW Counseling Program

Counselors, please evaluate your current supervisor based on the following items. Then make comments on the back, and sign below. Try to give feedback that will help your supervisor identify both strengths as well as areas for improvement.

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<th>Counselor Name:</th>
<th>Supervisor Name:</th>
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<thead>
<tr>
<th></th>
<th>Not Observed</th>
<th>Not Effective</th>
<th>Effective</th>
<th>Very Effective</th>
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<tbody>
<tr>
<td>1</td>
<td>Helps create a safe environment</td>
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<td>2</td>
<td>Structures supervision sessions</td>
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<td>3</td>
<td>Provides useful feedback</td>
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<tr>
<td>4</td>
<td>Encourages my active involvement</td>
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<tr>
<td>5</td>
<td>Is available and accessible</td>
<td></td>
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<tr>
<td>6</td>
<td>Encourages questions</td>
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<tr>
<td>7</td>
<td>Helps me understand client dynamics</td>
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<tr>
<td>8</td>
<td>Supports me</td>
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<tr>
<td>9</td>
<td>Challenges me to grow</td>
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<tr>
<td>10</td>
<td>Helps me look at my own issues</td>
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<td>11</td>
<td>Provides helpful suggestions</td>
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<tr>
<td>12</td>
<td>Is flexible and open</td>
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<td>13</td>
<td>Is fair and respectful</td>
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<td>14</td>
<td>Helps me address ethical issues</td>
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<td>15</td>
<td>Helps me with client documentation</td>
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<td>16</td>
<td>Is multiculturally responsive</td>
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<td>17</td>
<td>Invites self-reflection / evaluation</td>
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<td>18</td>
<td>Seeks my ideas and input</td>
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<td>19</td>
<td>Helps me consider my own theory</td>
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On a scale from 1 - 10, (1= very poor, 10=excellent), circle the number that reflects your perception of this supervisor's work with you (their support of your clinical work and growth).

1 2 3 4 5 6 7 8 9 10

What did you find helpful about your supervisor?

What do you wish your supervisor had done differently?

Please use the back-side to make any additional comments that might help your supervisor understand what they did well, and where they can work to improve.

Signature: _______________________________ Date: __________________________
Supervision Note

Supervisor: _______________________________ Date: ______________

Supervisees: ____________________________________________

Summary of Supervision: (list clients discussed, client progress, plans, training issues, safety issues, etc.)
_________________________________________________________________________________________
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Follow-Up Issues: (specific steps to be taken by supervisees prior to next supervision)
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Supervisor Signature _______________ Date _______________ Supervisee Signature _______________ Date _______________

Supervisee Signature _______________ Date _______________