Appendices

CETC Handbook 2016 – 2017

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

- **Request for Services Form** – The screening form used when clients first request services.
- **Consent to Receive Counseling Services** – Disclosure and informed consent. Must be signed by the client at the beginning of the first session.
- **Consent for Minor to Receive Counseling Services** – Disclosure and informed consent used with minors. Must be signed by a legal guardian before or at the beginning of the first session. For Lab-School clients, form is often sent before referral to you is made.
- **Child Assent to Receive Counseling Services** – Form to invite a child's (6-12) participation in counseling, must be accompanied in the file by a Consent signed by a guardian.
- **Consent for Research Participation** – Form used to request client permission to use their session information in research – do not use unless instructed to.
- **Client Information** – Basic information questionnaire that clients must fill out at first session - and which you must review *before* you begin counseling in the first session.
- **Client Information – Child/Adolescent** – Client information form to be filled out by parents when a minor is seen in the clinic for services.
- **Client Information – Couple/Family** – Each adult coming in for couple or family counseling should complete this version of the Client Information form.
- **Mental Status Exam Checklist** – Checklist of items completed by hand after first session.
- **Intake Interview Guidelines** – Some basic ideas for conducting an intake session with a client. Includes a brief outline that you may take into session with you.
- **Intake Summary / Intake Summary Guidelines** – Form to summarize basic client information, clinical impressions, diagnosis, and treatment plans. Must be completed before the third session.
- **mGAF – cGAS – GARF** – Charts to use for the GAF portion of the diagnosis on the intake summary, depending on the client (adult, child, couple/family).
- **Session Note** – Form to document the content and process of all sessions and 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 sessions.
- **Outcome Rating Scales / Session Rating Scales / PLot** – 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, and with adults, the summed scores entered on the SRS-ORS Scores Plot. Select the form that best fits the client's developmental level.
- **Contact Note** – Form to document non-session contact with clients and others, including cancellations.
- **Counseling 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 seen in the clinic.
- **Client Feedback Form** – Given to clients after their file is closed for counselor feedback.

- **Consent to Bilateral Release of Information** – Forms to obtain permission to exchange information with other professionals – second form is just for use with lab-school child clients.
- **Information about Substance Use Assessments** – Informational shared with clients before a substance use evaluation explaining the process.
- **ASI Substance Use Evaluation – Client Form** – The form clients complete to begin a substance use evaluation.
- **ASAM Assessment Dimensions** – Lists and defines important assessment dimensions for substance use evaluations. These will be used for making treatment recommendations.
- **ASAM Adult Placement Criteria** – Describes criteria for level of care recommendations.
- **Substance Use Evaluation Results Letter** – Letter to send the results to a judge/others.
- **Confirmation of Counseling Letter** – This letter is used to share a client's participation in counseling services.
- **Closing Letter** – This letter is to be used to let a client that cannot otherwise be contacted that you are going to close the file.
- **Client Safety Plan** – Form to fill out with a client who needs some specific direction and focus for staying safe when feeling suicidal.
- **Clinical Documentation Timeline** – Chart showing what documents must be completed during each session, or prior to the next section. Also posted in the clinic workroom.
- **Client File Organization** – chart showing the order and placement of all clinical documents in the client chart. Also posted in the clinic workroom.
- **Counseling Student's Clinical Log** – Form used to document clinical and supervisory hours during one semester – must be typed, all columns totaled and professional looking.
- **Counseling Student's Clinical Log – Summary** – Form used to summarize clinical and supervisory hours across your whole program – must be typed and professional looking.
- **Counseling Skills Evaluation Form** – Form used by supervisors to evaluate students' clinical skills, found on clinic workroom computers (note different forms for MS and Ph.D. Students).
- **Counselor Evaluation of the Supervisor Form** – Form used by students to give written feedback to their individual/triadic supervisors.
- **Block Feedback Form** – Form for students to give written feedback to their block supervisors.
- **Reflective Self-Supervision Form** – Form to be used to assist you in reflecting on your contribution to clinical sessions, and to assist in developing self-supervision skills.
- **Supervision Note** – Form used by individual/triadic supervisors to document client and counselor skill review during supervision.
- **Weekly Supervision Report** –Form to share MS supervisee progress and needs among supervisors and instructors.
- **Leeds Alliance in Supervision Scale & Plot** – Forms used by supervisors each session to solicit and plot feedback from supervisees about the supervisory alliance.
- **CETC Organizational Chart** – Chart overview of clinic management roles.

University of Wyoming
Dept. of Professional Studies -
Counseling Program
Dept. 3374

Counselor Education Training Clinic

C. E. T. C.

Helping Individuals, Couples, and Families to Thrive

1000 E. University Avenue
Laramie, WY 82071
(307) 766-6820
e-mail: CETC@uwyo.edu

Request for Services

Name: _____ Date Contacted: _____

Age: _____ ☐ Female ☐ Male ☐ Other

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 video-recorded, 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. Are you currently a student at the University of Wyoming? ☐ Yes ☐ No
4. Currently receiving Counseling: ☐ Yes ☐ No _____

   If yes, share that we don't provide concurrent service unless a different modality (group, family, etc)
5. Previous Counseling History? (When, for how long, what for): _____

   _____

   _____
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 (describe): _____

9. Possible Dual Relationships – currently taking a counseling course, knows counselor in clinic, other
   ☐ Denied ☐ Acknowledged (who, nature): _____

10. Readiness for Change Scale (self-rated) _____ 1= ambivalent, 5 = eager

11. Special accommodations: ☐ No ☐ Yes (describe): _____

12. Appropriate CETC Counselor Level:
    - ☐ Master's Student
    - ☐ Doctoral Student
    - ☐ ASI Evaluation

13. Times available for 50 min. counseling appointments (circle):

Blocks:					
	Mondays:	5:00 pm	6:00 pm	7:00 pm	8:00 pm
	Tuesdays (Ph.D.):	5:00 pm	6:00 pm	7:00 pm	8:00 pm
	Wednesdays:	5:00 pm	6:00 pm	7:00 pm	8:00 pm
	Thursdays:	9:00 am	10:00 am	11:00 am	12:00 pm
		2:00 pm	3:00 pm	4:00 pm	5:00 pm
	Fridays:	10:00 am	11:00 am	12:00 pm	1:00 pm

Other (Ph.D.): _____

14. Assignment / Appointment:
    Counselor: _____
    Date & Time of First Appointment: _____
    Counselor informed ☐ (date): _____

☐ Not appropriate for CETC Services
    Reason: _____
    Referred to: _____

Notes: _____

_____

_____

_____

_____ _____
Clinic Coordinator Signature Date

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Consent to Receive Counseling Services

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 most 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:
Where an immediate threat of self-inflicted harm exists;
Where an immediate threat of physical violence against a readily identifiable victim exists;
Where there is reasonable suspicion of abuse/neglect against a child, elder, or other dependent adult;
Where a judge has ordered the release of privileged information;
In the course of criminal or civil actions initiated by you against the counselor;
The disclosure is made to medical personnel in a medical emergency;
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: Research has found that counseling is more successful when the counselor and client work together to identify areas for change and ways to create change. You can help make counseling successful by attending all scheduled sessions on time, working with your counselor to identify things to work on and ways to work on them, and then making a sincere effort to practice the things that you and your counselor come up with. Toward the end of each session, your counselor will ask you how counseling is going for you and to identify how you can improve your work together. Your honest answers will improve the services you receive. 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.

Client Signature	Date	Parent/Guardian (if client is a minor)	Date
Client Signature	Date	Counselor Signature	Date
Client Signature	Date	Supervisor Signature	Date

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Dept. 3374

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Consent for Minor to Receive Counseling Services

Today's Date: _____

Child's Name: _____ Child's Age: _____ Grade: _____

Guardian Name: _____ Relationship to Child: _____

Guardian Address: _____

Guardian Phone: _____ Okay to leave a message? ☐ Yes ☐ No

Child's School: _____ Teacher: _____

This form is required by the Mental Health Professions Licensing Act and will give you some information about the services we provide. If you have any questions, please contact the clinic at 766-6820. Counselors at the C.E.T.C. are graduate students working toward an advanced degree in counseling. They are qualified to provide mental health services under supervision. All counselors-in-training are directly supervised both by qualified doctoral students and by the department's clinical faculty. The clinic is open weekdays from September through the end of May, except during university holidays (winter, spring break, etc.)

Sessions are usually held once a week, for 30-45 minutes, and we make every effort to schedule sessions so as not to interfere with your child's education. Sometimes counseling work with children involves play, since children naturally communicate and work through their feelings and experiences with play. Any play in session is considered therapeutic work, not free time. If you have questions about this, please speak with your child's counselor.

Because trust and honesty are critical to the development of all counseling relationships, we place a high value on the privacy of information you or your child share during counseling sessions. Counselors and their supervisors will not share any information about your child's counseling to anyone without your written permission, except when sharing information is required by law. Wyoming statute 33-38-113 requires that a report be made when there is reasonable suspicion of child, dependent or elder abuse and neglect. Counselors are also required to break confidentiality when a client presents a danger to self or others. In some legal proceedings, clinical records may be subpoenaed. As a training clinic, we video record every session. These recordings are used in the counselors' ongoing professional training and regular supervision. These are kept secure and confidential, and will be destroyed at the end of the school year. We will not use these recordings for any other purpose without your written permission.

To better help your child, we will probably want to visit with you as we begin, and then again from time to time. Please let us know anytime there is something that might assist us to understand and help your child. You have the right to request information regarding your child's services. We let children know when we are going to visit with their caregivers, and then share only summary information so that the child's privacy is respected.

Because we are a separate agency, and not part of the School District, we are unable to communicate back with the school counselor or your child's teacher unless we have your written permission to do so. The school counselor, or your child's CETC counselor can provide you the consent form giving us permission to visit. If your child is seeing a counselor in the community, we would like to visit briefly with him/her as well, to make sure we support each other's work and do not confuse your child. An additional copy of the same consent form will work.

You and/or your child have the right to discontinue counseling at any time, but it is usually best to do so only after discussing the decision with the counselor. Please contact us if this is something you are considering. We can also provide you with the names of other qualified professionals whose services you may prefer.

If you have any concerns about your child's counseling, please discuss them with your child's counselor, or you may contact the Clinic Director (766-6820). If we are unable to resolve your concerns, or you wish to obtain further information or report a complaint, you may contact the Wyoming Mental Health Professions Licensing Board, 2001 Capitol Avenue, Room 104; Cheyenne, WY 82002; (307) 777-7788.

I give permission for my child to receive counseling services at the C.E.T.C. as outlined above.

_____ _____

Guardian Signature Date

✶ *Please fill out the back side of this form to help us understand your child and any concerns you may have.*

Revised 2014 08

Parent / Guardian:
Please briefly note any concerns you have about your child—what do you hope your child gets out of counseling—as well as anything else that will help us understand your child.

_____

_____

_____

_____

_____

_____

_____

_____

Has anything happened recently or in your child's past that might be helpful for us to know? (move, divorce, death of pet or loved-one, other life changes, trauma, etc. . .)

_____

_____

_____

_____

_____

_____

Is your child receiving counseling from anyone else at this time? ☐ No ☐ Yes

If yes, it would be very helpful for us to visit with the other professional(s), please ask about a *Consent to Bilateral Release Information* form.

School (Teacher / Administrator / Counselor):
Please briefly note any concerns you have about the child—what would you like to see change as a result of counseling?

_____

_____

_____

_____

_____

_____

_____

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Child Assent to Receive Counseling Services

I am your counselor in the clinic and my name is _____. My number at the clinic is (307) 766-6820 if you need to call me. I have supervisors who helps make sure that I am doing the best job I can. My supervisor's name is _____.

We will meet every week. This time is for you. I am here to listen to anything you would like to talk about and to help you in any way I can. We can set goals together and work on them all semester. Please ask me any questions you have about counseling.

I will visit with your parents / caregivers about once a month to let them know how you are doing, but I won't share with them thing things you tell me. What you tell me is kept private, unless you tell me you are being hurt by someone, or if you are planning to hurt yourself or someone else. Then I will talk to your parents or caregivers, your school counselor, or your teachers about the best way to help keep everyone safe.

I work with a few other counselors in a team. With the camera in the room they can watch from another room and later share their ideas with me about how to help you. You can meet them if you want. I also record our time together so that my team and supervisors can help me to learn to help you better.

If you need to talk outside of our normal time but I'm not here, you can leave me a message, or speak to your parents/caregivers or to your school counselor, and they can get a message to me.

Child Client Date

Counselor Date

Supervisor Date

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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: _____

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Client Information

► 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: _____

Briefly describe the reason you decided to seek our services:

_____

_____

Relationship Status:

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

Who do you currently live with? _____

Current Occupation: _____

Place of Employment: _____

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 or over-the-counter medications or 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

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

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

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
- ☐ Moody 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 you 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

University of Wyoming
Dept. of Professional Studies -
Counseling Program
Dept. 3374

Counselor Education Training Clinic

C. E. T. C.

Helping Individuals, Couples, and Families to Thrive

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(307) 766-6820
e-mail: CETC@uwyo.edu

Client Information – Child/Adolescent

► **Parent/Guardian:** Please fill this form out completely. The information will help your child's counselor begin to understand your child and family to better help you both.

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name(s): _____

Local address: _____

Phone where Parent/Guardian can be reached: _____

Name of Person Completing this form: _____

Briefly describe the reason you decided to seek our services:

_____

_____

_____

Medical Information

Has your child 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 your child currently receive treatment:

_____

_____

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

Medication / Supplement Name	Dosage	Intended Purpose

When was your Child's last physical examination? _____

Family Information

Please list everyone who lives in the home with the child and any other people who are with the child a significant amount of time (baby-sitters, step-siblings, etc.)

Name	Age	Relationship to Child	☑ - lives with?
			☐
			☐
			☐
			☐
			☐
			☐

Parents are currently: ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Never married

Who has physical custody? _____ Who has legal custody? _____

Please describe the child's current living situation: _____

Do any of the parents/guardians have current legal issues? ☐ Yes ☐ No

Does anyone in the family have current / history of mental illness or addiction? ☐ Yes ☐ No

Do parents agree on methods of discipline? ☐ Yes ☐ No

What discipline works best, and in general, how does your child respond to this form of discipline?

School Information

Name of child's school: _____ Grade: _____ ☐ - does not attend

Has your child ever failed a grade or been held back? ☐ Yes (explain below) ☐ No

Has your child ever been suspended or expelled? ☐ Yes (explain below) ☐ No

Does your child have any behavioral or emotional concerns at school? ☐ Yes (explain below) ☐ No

List any special services/classes your child receives at school (IEP, other education plan, special-ed., gifted/talented; speech/language, tutoring, etc.)

Developmental Information

Please list any pregnancy/birth complications (preeclampsia, premature birth, C-section, jaundice, etc.)

During pregnancy, did mom regularly use/experience: ☐ Cigarettes ☐ Alcohol ☐ Drugs ☐ High stress

In the first two years of life, did your child experience any of the following:

☐ Abuse ☐ Neglect ☐ Other trauma ☐ Depressed mom

☐ Separations ☐ Parental stress ☐ Chronic pain ☐ Eating difficulty

Was anything in your child's development delayed or early (things such as smiling, talking, walking toilet training)? ☐ Yes (explain below) ☐ No

Has your child witnessed parental conflict and/or domestic violence? ☐ Yes (explain below) ☐ No

Please describe any other information about your child's development that you feel is important.

Child Information

Please mark all items that apply to your child:

☐ Temper, anger	☐ Sadness, depression	☐ Overly emotional
☐ Clingy (avoids being alone)	☐ Isolates (avoids others)	☐ Disobedient
☐ Bullies, teases	☐ Aggressive, fighting	☐ Low self-esteem
☐ Gets picked on, bullied	☐ Alcohol / drugs (circle)	☐ Anxiety, panic, nervousness
☐ Cheating	☐ Self-injury	☐ Risk taking
☐ Attention issues	☐ Lying	☐ Nightmares
☐ Disruptive	☐ Fears, phobias	☐ Physical complaints
☐ Eating problems	☐ Friendship problems	☐ Mood swings
☐ Confusion	☐ Immature	☐ Low energy, fatigue
☐ Stubbornness	☐ Impulsiveness, outbursts	☐ Perfectionism
☐ Wetting or soiling self	☐ Irresponsible	☐ Sexual Issues
☐ Problems with the law	☐ Stress issues	☐ Shy, timid

Please describe any of the above or any other issues your child is experiencing

Please list the three items from the list above or others that are causing your child the most difficulty:

Have there been any recent family changes / stressors? Mark all that apply within the last 12 months:

☐ Marital separation / divorce ☐ Death in family (pets too) ☐ Financial crisis
☐ Job difficulties / changes ☐ School problems ☐ Legal problems
☐ Medical problems ☐ Household move ☐ Extended separations
☐ Other changes / stresses (please describe): _____

_____

To your knowledge, has your child has ever experienced:

Physical abuse	☐ No	☐ Suspected	☐ Yes -	☐ Reported
Emotional abuse	☐ No	☐ Suspected	☐ Yes -	☐ Reported
Sexual abuse	☐ No	☐ Suspected	☐ Yes -	☐ Reported
Suicidal thoughts	☐ No	☐ Suspected	☐ Yes	
Suicidal actions	☐ No	☐ Suspected	☐ Yes	

Do you believe your child is safe right now? ☐ Yes ☐ No (explain below)

_____

_____

Other Information

Please list family, friends, support groups, pets or others that are helpful and supportive for your child:

_____

_____

_____

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

_____

_____

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

_____

Goals: What would you most like help with (what do you want to have different in your child's life)?

1 _____
2 _____
3 _____

Anything else you would like to share that will help your child's counselor understand and help your child:

_____

_____

_____

_____

_____ _____

Parent / Guardian Signature Date

University of Wyoming
Dept. of Professional Studies -
Counseling Program
Dept. 3374

Counselor Education Training Clinic

C. E. T. C.

Helping Individuals, Couples, and Families to Thrive

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e-mail: CETC@uwyo.edu

Client Information – Couple/Family

► 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: _____

Briefly describe the reason you decided to seek our services: _____

_____

_____

_____

Current Relationship Status (check all that apply):

☐ Single ☐ Dating
☐ Married ☐ Living Together
☐ Separated ☐ Engaged
☐ Divorced ☐ Widowed

If applicable, length of time in current relationship: _____

Who will be coming to counseling with you (list yourself first)?

Name	Age	Sex	Relationship to you
			Self

Who do you currently live with? _____

Your Current Occupation: _____

Place of Employment: _____

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 or over-the-counter medications or 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 concerns
- ☐ Brother / Sister problems
- ☐ Separation
- ☐ Divorce
- ☐ Dating difficulties
- ☐ Premarital issues
- ☐ Difficulties with friends

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

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/threatened)
- ☐ Physical abuse (past/current)
- ☐ Sexual abuse (past/current)
- ☐ Legal problems
- ☐ Major losses / changes
- ☐ Stress
- ☐ Difficulties with my past
- ☐ Difficulties with faith / spirituality
- ☐ Difficulties making decisions

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
- ☐ Moody 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 you 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: What do you hope happens because of counseling (what do you want to have different in your life and relationships)?

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 & your hopes:

_____

_____

_____

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

University of Wyoming
Dept. of Professional Studies -
Counseling Program
Dept. 3374

Counselor Education Training Clinic

C. E. T. C.

Helping Individuals, Couples, and Families to Thrive

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e-mail: CETC@uwyo.edu

Mental Status Exam Checklist

Client Name: _____ Date of Interview: _____

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

Comments: _____

_____

_____

Counselor Signature: _____ Supervisor Initials _____

Intake Interview Guidelines

You have four main goals in your Intake Interview (first session) with a client:

1. Establish rapport and begin building a professional therapeutic relationship – this is not a separate activity or event, but should be attended to at all times.
2. Obtain informed consent for services from the client and help the client begin to understand (intellectually and experientially) the process of counseling (roles, expectations, etc.).
3. Effectively evaluate and attend to any client urgent needs (suicidality, other crises)
4. Achieve a meaningful, accurate understanding of the client's mental functioning and behavior (including biological, psychological and social domains) to guide effective services

Although all of these goal will be ongoing throughout counseling, you need to adequately accomplish them within the first session so as to ethically and professionally provide services to the client. Below are some suggestions for areas of focus in the initial session. Remember that the intake session should not be an interrogation, but a collaborative conversation that helps both you and the client understand client concerns and begin to work collaboratively to resolve them. Your order may not be as linear as the areas are listed below. Be flexible with these guidelines so as to be responsive to your client's unique situation and needs. Use the Intake Interview Outline to help make sure you've adequately addressed each area in the first session so as to write a complete Intake Summary, and to guide conversations in future sessions.

1. <u>Obtain Informed Consent</u>:
   - Have clients complete the appropriate *Client Information* form and read the *Consent* form.
     - When complete, scan the *Client Information* for issue to be addressed today
   - Answer any client questions about consent, verbally review the limits to confidentiality (1. Harm to self or others; 2. Suspected abuse of child / elderly / disabled; 3. Very rare legal situations – if you need to defend yourself)
   - Discuss seeing each other outside of the clinic
   - Sign the consent form

2. <u>How Counseling Works</u>:
   - Weekly, 50 minutes, cancellation, phone messages
   - Work in clinical teams, mid-session consultation, video recording, supervision
   - Place to discuss difficult, challenging things, counselor will help and support, but not advise
   - Collaboration, client as active participant, client makes ultimate decisions
   - Brief, weekly check-in on how things going in general, and with counseling (ORS at beginning, SRS at end of each session)

3. <u>Present Client Concerns</u>:
   - Current problems / symptoms, including intensity, frequency and duration of symptoms
     - Ask specifically about anxiety, mood concerns, adjustment issues, substance use)
   - Identify any related / additional concerns (medical, legal, relationship, job / school, substance use) – use follow-up questions as necessary to obtain details
   - How do symptoms and concerns impact client functioning (bio-psycho-social)?
   - How has client attempted to cope / resolve the concerns? How effective / healthy?
   - Have the client fill out an ORS and graph it.

4. Crisis Evaluation & Attention:
   - Suicidal ideation or behavior, self-harm
   - Homicidal and / or violent ideation or behavior
   - Other safety issues (does the client feel safe?)

5. Background Information Relevant for Understanding the Client's Concerns:
   - Developmental factors
   - Relationship information (strengths and problems with historical and current support network, extent and quality of current supports)
   - Occupational history (school / work history, military service)
   - History of challenges and concerns (personal & family, including mental health, legal, abuse, other trauma, substance use, etc)
   - Previous experience with mental health services (counseling, hospital, other)
   - Client strengths and resources (bio-psycho-social)

6. Desired Services:
   - What does client hope to accomplish with counseling (initial goals)?
   - What does client think is needed to accomplish these goals?
   - How will the client know she is done with counseling?

* Remember to leave time for your initial SRS – Have the client fill it out, then graph it and discuss together what could be done to improve your work together.

Brief Intake-Interview Outline

Before you sit down with the client, review the Client Information form:

1. Obtain Informed Consent:

2. Explain the Counseling Process:

3. Explore Client Concerns:
   a. Duration, severity, history of current concerns
   b. Simultaneously seek any relevant Background Information
   c. Have the client complete an initial ORS form
   d. At any time if needed, do a crisis evaluation and respond appropriately

4. Get a Sense of the Client's Initial Goals:

5. Complete & discuss the initial SRS

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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. Diagnostic Statement / Case Conceptualization:

Click here to enter text.

DSM Diagnosis:

Mental Health Click here to enter text. Click here to enter text.

Medical Conditions: Click here to enter text.

Contextual Concerns Click here to enter text. Click here to enter text.

Global Assessment of Functioning (from mGAF, cGAS, or GARF):

GAF – Current = Click here to enter text. GAF – Best in Past Year = Click here to enter text.

VI. Initial Service Plan:

Click here to enter text.

Counselor Signature _____ Date _____ Supervisor Signature _____ Date _____

Intake Summary - Guidelines

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 how the client describes his/her reasons for seeking services (including current symptoms).

II. History of Present Difficulties: How long has the client experienced the current concern? Has it been continuous or 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? Describe all other acute stressors the client is currently experiencing.

III. Relevant Background Information: Identify developmental factors related to current concerns, including the nature of pertinent family and romantic relationships, educational and work history, military service, and other pertinent background. Briefly describe any history of difficulties (personal/family mental-health, substance abuse, trauma history, etc.), along with chronic stressors the client has experienced.

IV. Psychosocial Adjustment / Strengths and Resources: Nature and quality of social networks. Does the client receive meaningful social support at work, home, church, and other community 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 concern.

V. Diagnostic Statement / Case Conceptualization: The diagnostic statement summarizes your assessment findings and supports an accurate diagnosis in order to clearly document client need and support your service recommendations / plans.

Briefly summarize the most relevant bio-psycho-social data gathered in both formal and informal assessment. Include any information checked *present* on the MSE checklist, 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. For substance use evaluations, information from the ASI interview and the dimensional criteria for each domain on the current version of the ASAM placement criteria must be addressed in the assessment of a client's needs for services.

Next, use a theoretical and pragmatic framework to organize and make sense of (explain) the client's presentation (concerns and current functioning) and point the way to your counseling recommendations and plans. It can help to briefly describe how the client makes sense of their presenting concerns, but focus on providing a clear, coherent explanation for the client's current situation and needs based on your assessment and professional judgement.

DSM Diagnosis: You must include a full DSM-5 diagnosis here for all clients. List mental health concerns by priority with code and description – please use ICD-10 codes from DSM-5 (they're the ones in parentheses in the manual). Note any relevant medical conditions and how you know about them (MD report, client stated, etc.). Identify by code and description any contextual factors relevant to diagnosis and prognosis, then provide a GAF score (use the mGAF, cGAS, or GARF). 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 (including all sections) on the Client Progress section of a Session Note.

VI. Initial Service Plan: Provide your sense of the client's readiness for change. Briefly describe your recommendations / plans for treatment. These should be clearly connected to the diagnostic statement / case conceptualization, readiness for change, 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, play, etc.), frequency of sessions, estimated duration of treatment, and any referrals.

Modified Global Assessment of Functioning Scale (mGAF)

Adapted from: Hall, R. C. (1995). Global assessment of functioning: A modified scale. *Psychosomatics, 36,* 267-275.

Instructions: Identify the LOWEST possible score to accurately describe the client's overall level of personal functioning (including psychological, social, occupational/school, while excluding physical/environmental caused limitations). Descriptions and criteria in the scale are examples used to help you gain a general understanding of the different levels of client functioning and symptom severity.

01 – 10 In Immediate Danger of Severely Hurting Self or Others

Criteria A
- Serious suicidal act with clear expectation of death (e.g., stabbing, shooting, hanging, or serious overdose with no one present)
- Frequent sever violence or self-mutilation
- Extreme manic excitement, or extreme agitation and impulsivity (e.g., wild screaming and ripping the stuffing out of a bed mattress)
- Persistent inability to maintain minimal personal hygiene
- Urgent/emergency admission to present psychiatric hospital
- In acute, severe danger due to medical problems (e.g., severe anorexia or bulimia with heart/kidney problems, or spontaneous vomiting whenever food is ingested, or severe depression with out-of-control diabetes)

Scoring

01 – 03	A client who meets 5-6 criteria from group A
04 – 07	A client who meets 3-4 criteria from group A
08 – 10	A client who meets 1-2 criteria from group A

11 – 20 In some Danger of Hurting Self or Others

Criteria B
- Suicide attempts without clear expectation of death (e.g., mild overdose or cutting wrists with people around)
- Some severe violence or self-mutilating behaviors
- Severe manic excitement, or severe agitation and impulsivity
- Occasionally fails to maintain minimal personal hygiene (e.g., diarrhea due to laxatives or smearing feces)
- Urgent/emergency admission to the present psychiatric hospital
- In physical danger due to medical problems (e.g., severe anorexia or bulimia and some spontaneous vomiting or extensive laxative/diuretic/diet pill use, but without serious heart or kidney problems or severe dehydration and disorientation)

Scoring

11 – 13	A client who meets 5-6 criteria from group B
14 – 17	A client who meets 3-4 criteria from group B
18 – 20	A client who meets 1-2 criteria from group B

21 – 30 Inability to Function in Almost All Areas

Criteria C
- Serious impairment with work, school, or housework if a homemaker (e.g., unable to keep job or stay in school, or failing school, or unable to care for family and home)
- Frequent problems with the law (e.g., frequent shoplifting, arrests) or occasional combative behavior
- Serious impairment in relationships with friends (e.g., very few or no friends, or avoids what friends she/he has)
- Serious impairment in relationships with family (e.g., frequent fights with family and/or neglects family or has no home)
- Serious impairment in judgment (including inability to make decisions, confusion, disorientation)
- Serious impairment in thinking (including constant preoccupation with thoughts, distorted body image, paranoia)
- Serious impairment in mood (including constant depressed mood plus helplessness and hopelessness or agitation, or manic mood)
- Serious impairment due to anxiety (panic attacks, overwhelming anxiety)
- Other symptoms: some hallucinations, delusions, or severe obsessional rituals
- Passive suicidal ideation or mildly self-injurious behaviors that do not require medical attention

Criteria D
- Suicidal preoccupation or frank suicidal ideation with preparation
- Behavior considerably influenced by delusions or hallucinations
- Serious impairment in communication (sometimes incoherent, acts grossly inappropriately or profound stuporous depression

Scoring

21	A client who meets one of the criteria from group D
21 – 23	A client who meets 10 criteria from group C
24 – 27	A client who meets 8-9 criteria from group C
28 – 30	A client who meets 7 criteria from group C

31 – 40 Major Impairment in Several Areas of Functioning

Criteria C
Serious impairment with work, school, or housework if a homemaker (e.g., unable to keep job or stay in school, or failing school, or unable to care for family and home)
Frequent problems with the law (e.g., frequent shoplifting, arrests) or occasional combative behavior
Serious impairment in relationships with friends (e.g., very few or no friends, or avoids what friends she/he has)
Serious impairment in relationships with family (e.g., frequent fights with family and/or neglects family or has no home)
Serious impairment in judgment (including inability to make decisions, confusion, disorientation)
Serious impairment in thinking (including constant preoccupation with thoughts, distorted body image, paranoia)
Serious impairment in mood (including constant depressed mood plus helplessness and hopelessness or agitation, or manic mood)
Serious impairment due to anxiety (panic attacks, overwhelming anxiety)
Other symptoms: some hallucinations, delusions, or severe obsessional rituals
Passive suicidal ideation

Scoring

31 – 33	A client who meets 6 criteria from group C
34 – 37	A client who meets 5 criteria from group C
38 – 40	A client who meets 4 criteria from group C

41 – 50 Some Serious Symptoms or Serious Impairment in Functioning

Criteria C See Above

Scoring

41 – 43	A client who meets 3 criteria from group C
44 – 47	A client who meets 2 criteria from group C
48 – 50	A client who meets 1 criteria from group C

51 – 60 Moderate Symptoms and/or Moderate Impairment in Functioning

Criteria
Moderate symptoms (e.g., frequent, moderate depressed mood and insomnia and/or moderate ruminating and obsessing, or occasional anxiety attacks, or flat affect and circumstantial speech, or eating problems and below minimum safe weight without depression)
Moderate difficulty in social, work, or school functioning (e.g., few friends, or conflicts with peers)

Scoring

51 – 53	A client with both moderate symptoms and moderate difficulty in social, work/school functioning
54 – 57	A client with moderate difficulty in more than one area of social work/school functioning
58 – 60	A client with either moderate symptoms or moderate difficulty in social, work/school functioning

61 – 70 Some Persistent Mild Symptoms and/or Mild Impairment in Functioning

Criteria
Mild symptoms are present that are **not** just expectable reactions to psychosocial stressors (e.g., mild or lessened depression and/or mild insomnia)
Some persistent difficulty in social, work, or school functioning (e.g., occasional truancy, theft within the family, or repeated falling behind in school or work)
But has some meaningful interpersonal relationships

Scoring

51 – 53	A client with both moderate symptoms and moderate difficulty in social, work/school functioning
54 – 57	A client with moderate difficulty in more than one area of social work/school functioning
58 – 60	A client with either moderate symptoms or moderate difficulty in social, work/school functioning

71 – 80 Some Transient Mild Symptoms and/or Slight Impairment in Functioning

Criteria
Mild symptoms are present, but they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument)
Slight impairment in social, work, or school functioning (e.g., temporarily falling behind in school or work)

Scoring

71 – 73	A client with **both** mild symptoms **and** slight impairment in social, work, and school functioning
74 – 77	A client with mild impairment in more than 1 area of social, work, or school functioning
78 – 80	A client with **either** mild symptoms **or** mild impairment in social, work, or school functioning

81 – 90 Absent or Minimal Symptoms & No Impairment in Functioning

Criteria
Minimal or absent symptoms (e.g., mild anxiety before an exam)
Good functioning in all areas and satisfied with life
Interested and involved in a wide range of activities
Socially effective
No more than everyday problems or concerns(e.g., an occasional argument with family members)

Scoring

81 – 83	A client with minimal symptoms and everyday problems
84 – 87	A client with minimal symptoms or everyday problems
88 – 90	A client with no symptoms or everyday problems

Children's Global Assessment Scale (CGAS)

Adapted from: Shaffer D, Gould MS, Brasic J, et al. (1983) A children's global assessment scale (CGAS). Archives of General Psychiatry, 40, 1228-1231.

Instructions: Identify the LOWEST possible score to accurately describe the child/adolescent's overall level of general functioning (including psychological, social, and school, while excluding physical/environmental caused limitations). Descriptions below serve as a *guide*, to help you gain a general understanding of the different levels of client functioning and symptom severity

01 – 10	In need of Constant Supervision for Safety

Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect or personal hygiene.

11 – 20	In Need of Considerable Supervision for Safety

Needs considerable supervision to prevent hurting others or self (e.g., frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication, e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.

21 – 30	Severe Impairment to Functionality

Unable to function in almost all areas e.g., stays at home, in ward, or in bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate).

31 – 40	Major Impairment to Functionality

Major impairment of functioning in several areas and unable to function in one of these areas i.e., disturbed at home, at school, with peers, or in society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behavior due to either mood or thought disturbance, suicidal attempts with clear lethal intent; such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).

41 – 50	Moderate Symptoms and/or Moderate Impairment in Functioning

Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor to inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.

51 – 60 Variable Functioning with Sporadic Difficulties

Variable functioning with sporadic difficulties or symptoms in several but not all social areas; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.

61 – 70 Some Isolated Difficulties but Generally Functioning Well

Some difficulty in a single area but generally functioning well (e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.

71 – 80 Some Transient Mild Symptoms and/or Slight Impairment in Functioning

No more than slight impairments in functioning at home, at school, or with peers; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separations, deaths, birth of a sibling), but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.

81 – 90 Good Functioning

Good functioning in all areas; secure in family, school, and with peers; there may be transient difficulties and ‘everyday’ worries that occasionally get out of hand (e.g., mild anxiety associated with an important exam, occasional ‘blowups’ with siblings, parents or peers).

91 – 100 Superior Functioning

Superior functioning in all areas (at home, at school, and with peers); involved in a wide range of activities and has many interests (e.g., has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc.); likeable, confident; ‘everyday’ worries never get out of hand; doing well in school; no symptoms.

Global Assessment of Relational Functioning (GARF)

Adapted from:
American Psychiatric Association (1994) *DSM-IV,* Washington, DC: Author.
Group for the Advancement of Psychiatry; Committee on the Family (1996). *Family Process, 35,* 155-172.

Instructions: The GARF scale can be used to indicate an overall judgment of the functioning of a family or other ongoing relationship on a hypothetical continuum ranging from disrupted, dysfunctional relating to competent, optimal relational functioning. The GARF scale permits the clinician to rate the degree to which a family or other ongoing relational unit meets the affective or instrumental needs of its members in the following areas:
Interactions: skills in negotiating goals, rules and routines; adaptability to stress; communication skills; ability to resolve conflict.
Organization: maintenance of interpersonal roles and healthy subsystem boundaries; effective and appropriate leadership; coalitions and distribution of power, control and responsibility.
Emotional Climate: tone and range of feelings; quality of caring, empathy, involvement, and attachment/commitment; sharing of values, mutual affective responsiveness, respect and regard; quality of partner sexual functioning.

Descriptions below represent the lower end of the numerical range and are not criteria, but serve to portray the kinds of relationship patters present.

It may be helpful to remember that all relationship vary by cohesion (sense of togetherness) and adaptability. In most cases extremes on either or both dimensions are associated with dysfunction (cohesion extremes = disengaged / enmeshed; adaptability extremes = chaotic / rigid).

01 – 20 Too dysfunctional to retain continuity of contact and attachment

Relational routines are negligible (e.g. no mealtime, sleeping or waking schedule); members often do not know where others are or what to expect from one another; there is little effective communication; communication is regularly disrupted by misunderstanding and "talking past one another."
Personal and generational responsibilities toward one another are not accepted or recognized; boundaries of relational unit as a whole and subsystems cannot be identified or agreed upon; persons in the relationship may physically endanger, injure or sexually attack one another.
Despair and cynicism are pervasive; there is little attention to the emotional needs of others; there is almost no sense of attachment, commitment, or concern about one another's welfare.

21 – 40 Relationships are obviously and seriously dysfunctional; forms and time periods of satisfactory relating are rare

Relational patters/routines do not meet the needs of members; established expectations are ignored, or are grimly adhered to, despite change in circumstances; life-cycle transitions, such as departures from or entries into the relationship, generate painful conflict and obviously frustrating failures of problem solving.
Decision making is tyrannical or quite ineffective; the unique characteristics of individuals are unappreciat5ed and ignored by either rigid or confusingly fluid coalitions.
Periods of enjoyment of life together are infrequent; obvious distancing or open hostility reflect significant , enduring conflicts that remain unresolved and painful; serious sexual dysfunction among adult members is commonplace.

41 – 60 Clearly unsatisfying relationships predominate; occasional times of satisfying/ competent functioning together

Communication, problem solving, and routine activities are quite frequently inhibited or impacted by unresolved conflicts; there is significant difficulty in adapting to stressors and transitional changes.

Decision making is only intermittently competent and effective; either excessive rigidity or significant lack of structure is evident at these times; individual needs are quite often submerged by a partner or a coalition.

Pain and/or ineffective anger or emotional deadness interfere with shared enjoyment; although there is some warmth and support for members, it is usually unequally distributed; troublesome sexual difficulties between adults are often present.

61 – 80 Functioning is somewhat unsatisfactory; over time, many but not all difficulties are resolved without major complaint

Daily routines are present but there is some pain and difficulty responding to the unusual; Ordinary relational problems are handled adequately; some issues are burdensome and remain unresolved but do not seriously disrupt the relationship.

Decision making is usually competent, but efforts at control of one another sometimes are greater than necessary and/or are ineffective; individuals and coalitions are clearly demarcated but sometimes are depreciated or scapegoated.

A range of feelings is expressed, but instances of emotional blocking or tension are evident; warmth and caring are present but are marred by irritability, pain, and frustration; sexual activity of adult members may be somewhat unsatisfactory or problematic.

81 – 100 Satisfactory functioning according to members and observations of others

Agreed-upon patters or routines exist that help meet the usual needs of each member; there is flexibility for change in response to unusual demands or events; occasional conflicts and stressful transitions are resolved through problem-solving communication and negotiation.

There is a shared understanding and agreement about roles and responsibilities for appropriate tasks; the unique characteristics and merits of each subsystem (parents/spouses, siblings, individuals) are recognized and respected.

The relational atmosphere is situationally appropriate and optimistic; a wide range of feelings is freely expressed and managed; there is a general atmosphere of warmth, caring and sharing of values among all members; sexual relations of adult members are satisfactory

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Laramie, WY 82071
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e-mail: CETC@uwyo.edu

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

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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	☐ Helpless	☐ Powerless
☐ Power / Control	☐ Nurturing	☐ Reparation	☐ Hopeless
☐ Dependency	☐ Grief & Loss	☐ Resiliency	☐ Anxiety
☐ Revenge	☐ Abandonment	☐ Chaos / Instability	☐ Other:
☐ Safety / Security	☐ Protection	☐ Perfectionism	Click here to enter text.
☐ Mastery	☐ Separation	☐ Integration	

Plan / Recommendations:

Click here to enter text.

Next Session: Click here to enter a date.

Counselor Signature _____ Date _____ Supervisor Signature _____ Date _____

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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. **Session #:** 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)

Name: _____ Age (yrs): _____ Gender: _____

Session # _____ Today's Date _____

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

If other, what is your relationship to this person? _____

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.*

Individually
(Personal well-being)

|----------|

Interpersonally
(Family, close relationships)

|----------|

Socially
(Work, school, friendships)

|----------|

Overall
(General sense of well-being)

|----------|

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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?)

|----------|


Family

(How are things in my family?)

|----------|


School

(How am I doing at school?)

|----------|


Everything

(How is everything going?)

|----------|


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Young Child Outcome Rating Scale (YCORS)

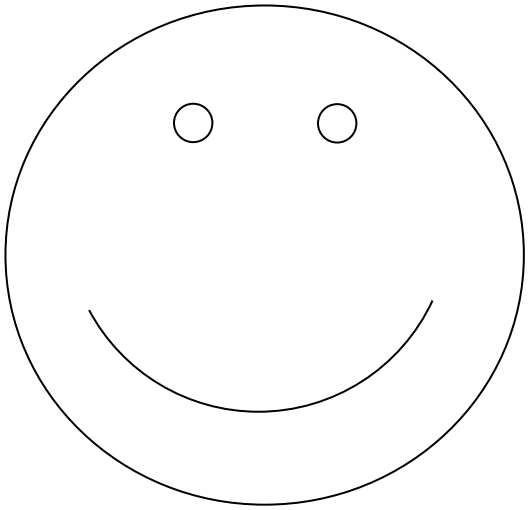
Name: _____ Age (yrs): _____ Gender: _____

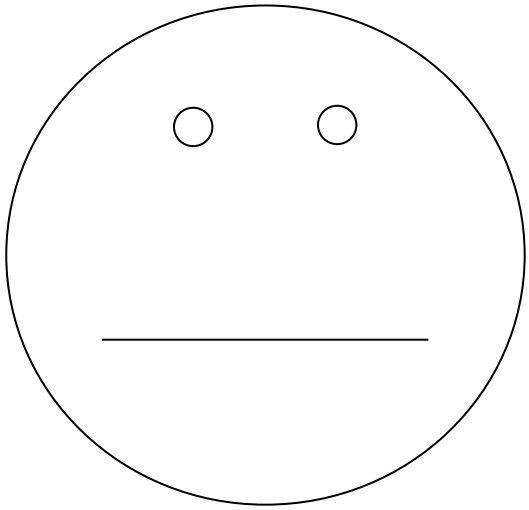
Session # _____ Today's Date _____

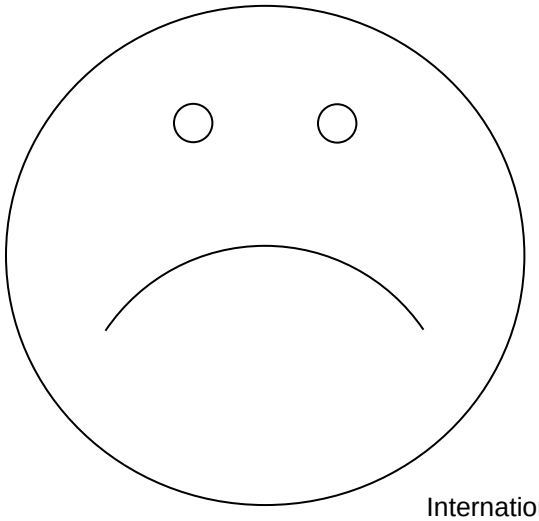
Who is filling out this form? Please check one: Child ☐ Caretaker ☐

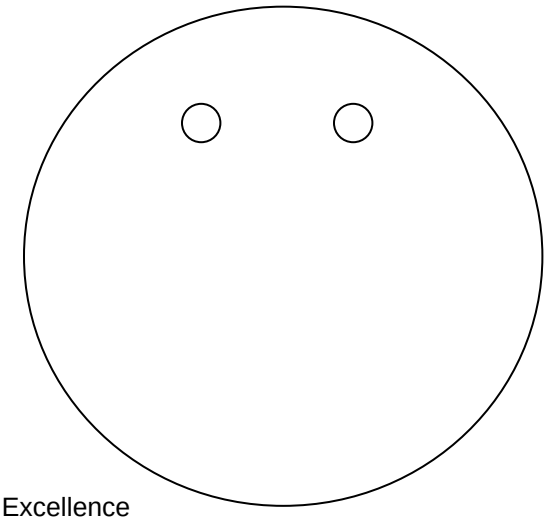
If caretaker, what is your relationship to this child? _____

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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Session Rating Scale (SRS V.3.0)

Name: _____ Age (yrs): _____ Gender: _____

Session # _____ Today's Date _____

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----------I 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. I----------I 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. I----------I The therapist's approach is a good fit for me.

Overall

There was something missing in the session today. I----------I Overall, today's session was right for me.

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Child Session Rating Scale (CSRS)

Name: _____ Age (yrs): _____ Gender: _____

Session # _____ Today's Date _____

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.	I----------   ----------I	listened to me.

How Important

What we did and talked about was not really that important to me.	I----------   ----------I	What we did and talked about were important to me.

What We Did

I did not like what we did today.	I----------   ----------I	I liked what we did today.

Overall

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

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Young Child Session Rating Scale (YCSRS)

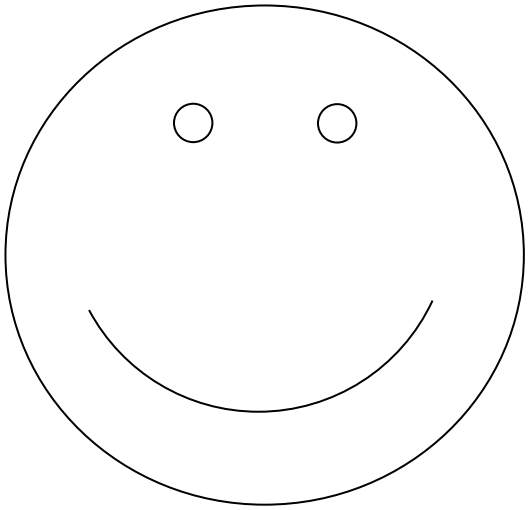
Name: _____ Age (yrs): _____ Gender: _____

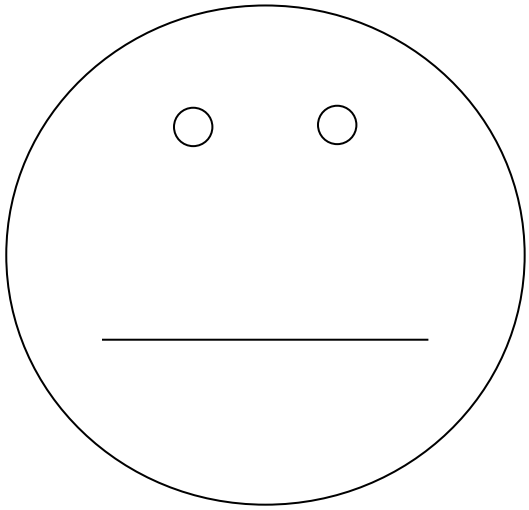
Session # _____ Today's Date _____

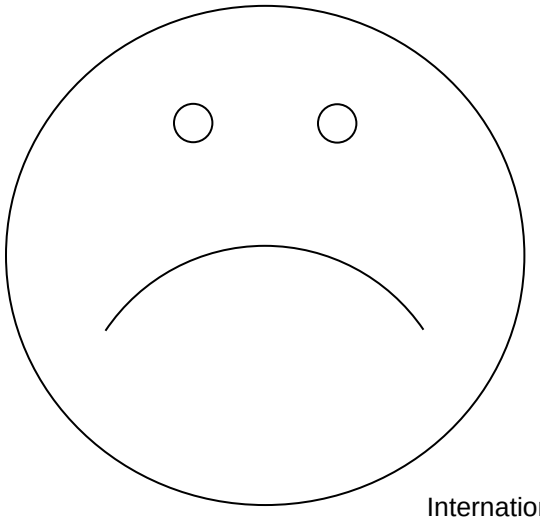
Who is filling out this form? Please check one: Child ☐ Caretaker ☐

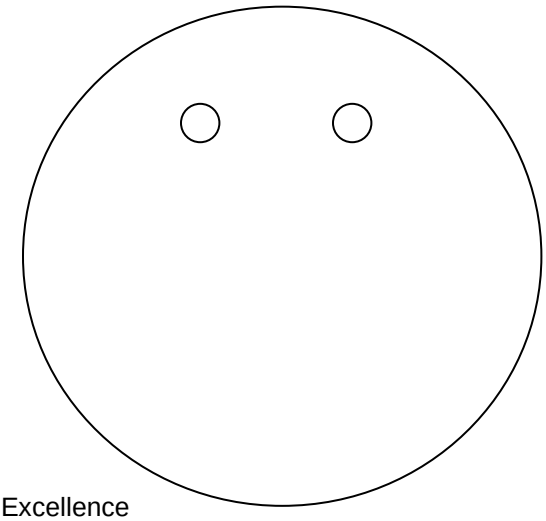
If caretaker, what is your relationship to this child? _____

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.









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----------I

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.

I----------I

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.

I----------I

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.

I----------I

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

I----------I

This supervision session was focused

Relationship

My supervisor and I did not understand each other in this session

I----------I

My supervisor and I understood each other in this session

Meeting My Needs

This supervision session was not helpful to me

I----------I

This supervision session was helpful to me

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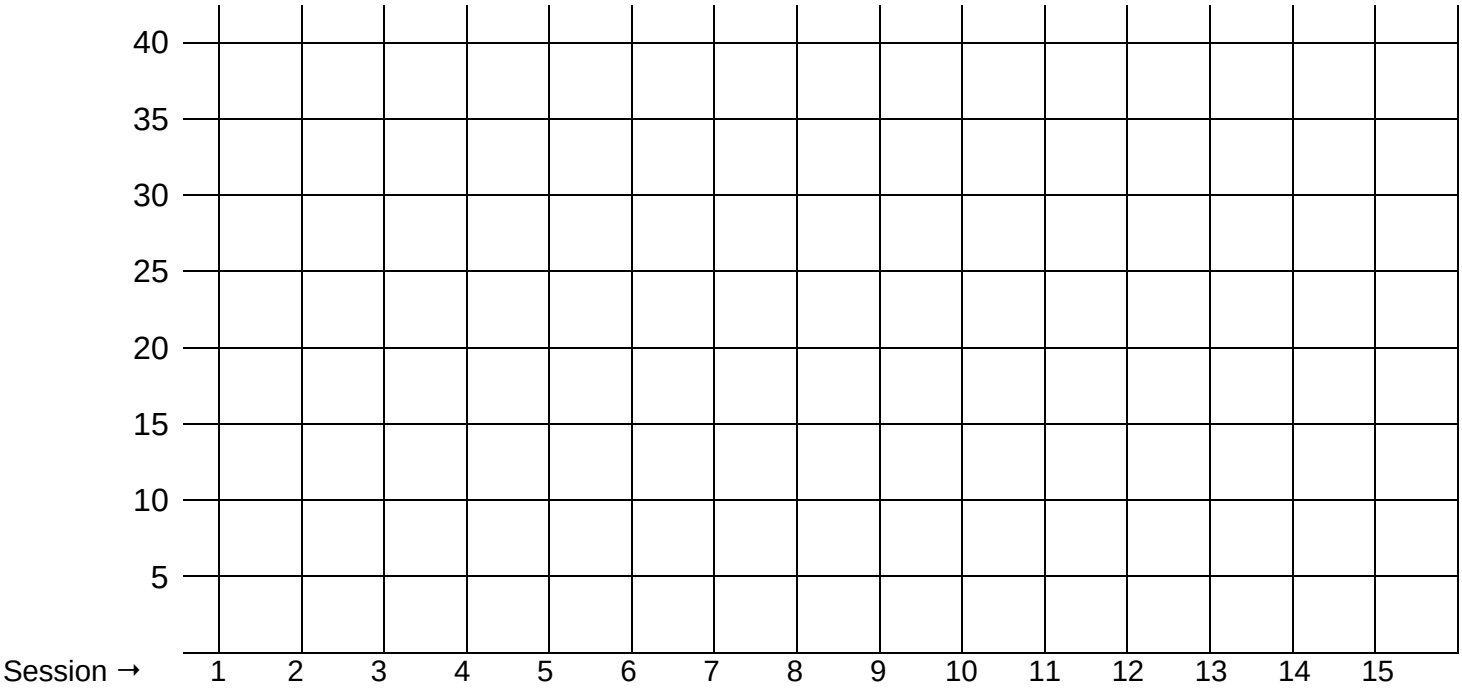
SRS-ORS Scores Plot

Client Name: _____ **First Session Date:** _____

Counselor: _____ **Final Session Date:** _____

Counselor: each week after your client has filled out the SRS and ORS rating sheets, plot the summed scores for each rating sheet on the chart below, and discuss with the client her/his ratings, seeking understanding about what is working well and could potentially be amplified, as well as what is not working well and which might be modified. Also discuss with the client trends in both scores across sessions. Because the point here is to use these scores as an invitation to discuss ways to improve the therapeutic alliance and client outcomes, merely obtaining and plotting the scores is insufficient.



Key: ORS Scores: ——×——×——

SRS Scores: ---●-------●---

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Contact Note

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

Contact with: Click here to enter text.

Relationship to Client: Click here to enter text.

Summary of Contact:

Click here to enter text.

Counselor Signature | Date | Supervisor Signature | Date

University of Wyoming
Dept. of Professional Studies -
Counseling Program
Dept. 3374

Counselor Education Training Clinic

C. E. T. C.

Helping Individuals, Couples, and Families to Thrive

1000 E. University Avenue
Laramie, WY 82071
(307) 766-6820
e-mail: CETC@uwyo.edu

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 0 = no progress, 1 = little progress, 2 = some progress, 3 = much progress, 4 = outcome achieved), 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

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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 Session:	Click here to enter a date.	Individual Sessions:	Click here to enter text.
Last Session:	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-Shows	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 _____

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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 their future work with people like yourself. 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 time with your counselor?

Thank you for your help

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Consent to Bilateral Release of Information

Client Name: _____ **Date of Birth:** _____

Counselor Name: _____ **Date:** _____

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

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

Name of Professional | Title | Name of Organization

Mailing Address

City | State | Zip Code | Phone Number

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)
Month Day Year

► 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

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Counselor Education Training Clinic

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Consent to Bilateral 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

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

UW Lab School (Counselor, Teachers, Administrators)
Name of Professional — Name of Organization

Education Bldg. # 132; University of Wyoming
Mailing Address

Laramie, WY, 82071 **(307) 721-2155**
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)
Month Day Year

► 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

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Information about Substance Use Assessments

Most people who request a Substance Use Evaluation are concerned about whatever event led them to seek the evaluation, and want to quickly take care of their responsibilities and move on with their life. We want to help you accomplish this, and help you find ways to avoid any future concerns from your use of alcohol and drugs.

The evaluation will involve one paper-work session, two or three assessment sessions with a counselor, and a final session to share with you the results of the evaluation and our professional recommendations. We follow the American Society of Addiction Medicine guidelines in our assessment and in making service recommendations. These guidelines are used by all providers who are certified to provide substance use evaluations. If needed, we can send a summary of our assessment and recommendations to other professionals as requested by you. The whole process will take approximately 4-5 weeks.

We will work to understand the events that led to this evaluation, how drugs and alcohol are impacting your life, and how other areas of your life may be influencing your drug and alcohol use. We'll need to learn not only about your substance use, but also some about your history, your physical and emotional wellness, your relationships with others, and your perceptions about each of these things. Based on this information, we will make professional recommendations for doing things that can help you prevent any future negative consequences from alcohol/drug use or abuse. These may include things like attending individual counseling sessions, completing a substance use educational class, attending more intensive counseling support services, involving yourself with community support systems, and other self-care options.

Sometimes a person's alcohol and drug use or overuse is based on certain situations (personal celebrating, peer influence, phase of life, experimentation) and sometimes it is related to a more serious long-term issue. In either case, any time drug/alcohol use begins to negatively affect you (by restricting your freedom, costing you money, hurting your health, grades, employment, your relationships or other areas of your life) it is already a problem, even if you think you are in control of your use.

Very often, people want to just get on with life and may want to share information with us that isn't exactly true, or try to present themselves in a good light, because they think it will make their lives easier. This usually ends up causing people more problems. It often leads to additional costs, legal issues, and other negative consequences, and delays them from receiving services that can help them prevent future problems. The best way to help yourself is to be fully honest in all that you share with us during the evaluation so that your counselor can make the best recommendation for helping you move toward the kind of life that you want – free from all the problems that you can prevent.

Please let us or your counselor know if you have any questions or concerns during the process.

Revised 2015 . 08

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ASI Substance Use Evaluation – Client Form

Instructions: Please accurately and honestly complete all of the items below to the best of your ability (don't leave any spaces blank). Sometimes people may want to give answers that aren't exactly true. This usually ends up causing people more problems. The best way to help yourself is to be fully honest in all your answers so that your counselor can make the best recommendation for helping you prevent any future concerns.

Please write as clearly as possible. Your counselor will review the document with you to make sure she/he understands your answers, and to gather some additional information so as to best understand you and your unique situation, and to make informed recommendations for services to assist you.

Client Name: _____ **Date of Birth:** _____

Counselor Name: _____ **Today's Date:** _____

Local Address: _____

How long have you been at this address? _____ years & _____ months

Do you or your family own this address? ☐ - Yes ☐ - No

Phone Number: _____

Of what race(s) do you consider yourself? _____

What is your preferred religion or faith tradition? _____

Have you been in a controlled environment (hospital, jail, etc.) in the past 30 days? ☐ - Yes ☐ - No

If yes, then list where, for how long, and the reason: _____

_____

Referral

Who referred you for this evaluation?

Name: _____ Position: _____

Address: _____ Phone #: _____

Were you ordered to receive an assessment? ☐ - Yes ☐ - No B.A.C. (if applicable): _____

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

_____

Briefly explain why are you receiving this assessment, and the situation that led to it, including approximate dates of events (Arrest – OWI/DUI, Court Order, Attorney Recommendation, Self-Interest, other)

_____

_____

_____

_____

_____

_____

Medical Status

How many times in your life have you been hospitalized for medical problems (include any overdoses, delirium tremens, exclude detox)? or write "never." _____

How long ago was your last hospitalization for a medical problem? _____ years & _____ months

What was it for? _____

Do you have any chronic medical problems that continue to interfere with your life? ☐ - Yes ☐ - No

Specify: _____

_____

Are you taking any prescribed medication on a regular basis? ☐ - Yes (list below) ☐ - No

Medicine Name	What is it for?
▪ _____	_____
▪ _____	_____
▪ _____	_____
▪ _____	_____
▪ _____	_____

Do you receive financial compensation (pension, disability, etc.) for a physical disability? ☐ - Yes ☐ - No

Specify: _____

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

How bothered have you been by these medical problems in the past 30 days? (check one)

☐ - Not at all ☐ - Slightly ☐ - Moderately ☐ - Considerably ☐ - Extremely

How important to you now is treatment for these medical problems? (check one)

☐ - Not at all ☐ - Slightly ☐ - Moderately ☐ - Considerably ☐ - Extremely

Sometimes using controlled substances can increase a person's risk for contracting a communicable disease (STI / STD). Your counselor will share information with you about free screening and counseling for these communicable diseases. We are required to do so with any person who receives a substance use evaluation.

Employment / Support Status

What was the last year of school that you successfully completed (GED = 12th grade): _____

Please list any training or technical education you completed: _____

_____

Do you have a valid driver's license? ☐ - Yes ☐ - No

Do you have access to an automobile? (check "No" if you don't have a valid license) ☐ - Yes ☐ - No

How long was your longest full-time job? _____ years & _____ months

Briefly describe your usual (or last) paid work: _____

Does someone contribute financially to your support in any way? ☐ - Yes ☐ - No

Specify all: _____

_____

Does this constitute the majority of your financial support? ☐ - Yes ☐ - No

Current Employment Status (check all that apply):

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

☐ - Unpaid Volunteer ☐ - Retired / Disability ☐ - Unemployed

☐ - Student – Full time ☐ - Student – Part Time ☐ - 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? (write none if none)

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 financial support? _____

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

How bothered have you been by these employment problems in the past 30 days? (check one)

☐ - Not at all ☐ - Slightly ☐ - Moderately ☐ - Considerably ☐ - Extremely

How important to you now is counseling for these employment problems? (check one)

☐ - Not at all ☐ - Slightly ☐ - Moderately ☐ - Considerably ☐ - Extremely

Drug / Alcohol Use

What age did you first try alcohol or drugs? _____ What was it, and how much? _____

_____

Please tell us how often use have used the following substances in the past 30 day, in your lifetime, and the methods you've used to take these substances:

Substance	Past 30 days	Lifetime	Methods (oral, nasal, smoke, inject, IV)
Alcohol – any use at all			
Alcohol – to Intoxication			
Heroin			
Methadone			
Other opiates or analgesics			
Barbiturates			
Other sed / hyp / tranq			
Cocaine			
Amphetamines			
Cannabis (Marijuana)			
Hallucinogens			
Inhalants			
More than one per day			

Have you ever used a needle to administer any of these drugs? ☐ - Yes ☐ - No

Are you an IV drug user? ☐ - Yes ☐ - No

Which of the substances above seems most linked to the problems you experience? (List all that apply)

_____

How long was your last voluntary abstinence from this substance? _____ months

How many months ago did this abstinence end? _____ months ☐ - I'm still abstinent

How many times have you:

Had alcohol delirium tremens? (shaking, anxiety, disorientation when you stopped drinking) _____

Overdosed on drugs? _____ Blacked-out from drinking? _____

Received services for alcohol abuse? _____ How many for detox only? _____

Received services for drug abuse? _____ How many for detox only? _____

Have you ever received any services that included a focus on your substance use? ☐ - Yes ☐ - No

How long ago did you last receive services for substance use? _____ years & _____ months

What type of services did you receive? (check all that apply)

☐ - I've never had services ☐ - Inpatient (residential) ☐ - Intensive Outpatient

☐ - Education classes ☐ - Group Counseling ☐ - Individual Counseling

☐ - 12-step meetings (AA / NA) ☐ - Other (specify) _____

If you have received services at an inpatient or intensive outpatient program, tell us about the last time:

Name of center: _____

Address: _____

Length of the program? _____ Did you successfully complete it? ☐ - Yes ☐ - No

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

Have you ever been evaluated for alcohol or drug use before today? ☐ - Yes ☐ - No

When? _____ Where? _____

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

Alcohol? $ _____ Drugs? $ _____

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

Any problems from using alcohol? _____ Any problems from using Drugs? _____

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

☐ - Not at all ☐ - Slightly ☐ - Moderately ☐ - Considerably ☐ - Extremely

How troubled or bothered have you been in the past 30 days by problems from using drugs?

☐ - Not at all ☐ - Slightly ☐ - Moderately ☐ - Considerably ☐ - Extremely

Legal Status

Are you currently on probation? ☐ - Yes ☐ - No Parole? ☐ - Yes ☐ - No

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

Vandalism	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Parole / probation violations	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Drug Charges	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Forgery	_____/_____ Times	Under the influence	☐ - Yes	☐ - No
Weapons offences	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Breaking & enter	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Stealing	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Assault	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Arson	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Rape / sex-related crimes	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Homicide / manslaughter	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Prostitution	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No

Contempt of court	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Disorderly conduct	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Vagrancy	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Public intoxication	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Driving while intoxicated	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Minor in possession (MIP)	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Major driving violations	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No
Other: _____	_____/_____ Times	Under the influence?	☐ - Yes	☐ - No

How many months in your life have you been incarcerated? _____ months

How long was your last incarceration? _____ months

What was it for? _____

Are you presently awaiting charges, trial or sentencing? ☐ - Yes ☐ - No Which? _____

For what? _____

How many days in the past 30 days were you detained or incarcerated? _____ days

How many days in the past 30 days have you engaged in illegal activities for profit? _____ days

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

Family History / Social Relationships

How would you describe your current relationship 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 your current relationship status? ☐ - Yes ☐ - No ☐ - Don't Care

How many children do you have? _____ With how many different partners? _____

What has been your 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 has this been your living arrangement? (if with family or parents, since age 18) _____ years _____ months

Are you satisfied with these arrangements? ☐ - Yes ☐ - No ☐ - Don't Care

Do you live with anyone who:

Has a current alcohol problem? ☐ - Yes ☐ - No Relationship to you: _____

Uses non-prescribed drugs? ☐ - Yes ☐ - No Relationship to you: _____

With whom do you spend most of your free time? (family, friends, alone) _____

Are you satisfied spending your free time this way? ☐ - Yes ☐ - No ☐ - Don't Care

How many close friends do you have? _____

Do you feel you have had close relationships with any of the following people in your life? Are you currently close?

	We have been close in my lifetime			We are currently Close		
Father	☐ - Yes	☐ - No	☐ - N/A	☐ - Yes	☐ - No	☐ - N/A
Mother	☐ - Yes	☐ - No	☐ - N/A	☐ - Yes	☐ - No	☐ - N/A
Spouse / Partner	☐ - Yes	☐ - No	☐ - N/A	☐ - Yes	☐ - No	☐ - N/A
Siblings	☐ - Yes	☐ - No	☐ - N/A	☐ - Yes	☐ - No	☐ - N/A
Children	☐ - Yes	☐ - No	☐ - N/A	☐ - Yes	☐ - No	☐ - N/A
Friends	☐ - Yes	☐ - No	☐ - N/A	☐ - Yes	☐ - No	☐ - N/A

Have you had significant periods in which you experienced serious problems getting along with:

Relationship	Past 30 days			Lifetime			Was it influenced by alcohol or drug use?	
Mother	☐-Yes	☐-No	☐-N/A	☐-Yes	☐-No	☐-N/A	☐ - Yes	☐ - No
Father	☐-Yes	☐-No	☐-N/A	☐-Yes	☐-No	☐-N/A	☐ - Yes	☐ - No
Siblings	☐-Yes	☐-No	☐-N/A	☐-Yes	☐-No	☐-N/A	☐ - Yes	☐ - No
Spouse / Partner	☐-Yes	☐-No	☐-N/A	☐-Yes	☐-No	☐-N/A	☐ - Yes	☐ - No
Children	☐-Yes	☐-No	☐-N/A	☐-Yes	☐-No	☐-N/A	☐ - Yes	☐ - No
Other Family	☐-Yes	☐-No	☐-N/A	☐-Yes	☐-No	☐-N/A	☐ - Yes	☐ - No
Close friends	☐-Yes	☐-No	☐-N/A	☐-Yes	☐-No	☐-N/A	☐ - Yes	☐ - No
Neighbors	☐-Yes	☐-No	☐-N/A	☐-Yes	☐-No	☐-N/A	☐ - Yes	☐ - No
Coworkers	☐-Yes	☐-No	☐-N/A	☐-Yes	☐-No	☐-N/A	☐ - Yes	☐ - No

Did any of these people abuse you? Write who (Father, Sibling, etc), none, or just write "Yes" or "Multiple" if you don't want to identify the relationship

	Who in the past 30 days?	Who in your lifetime?
Emotionally (made you feel bad)		
Physically (caused you physical harm)		
Sexually (forced sexual activity)		

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 / DK – don't know)

Person	Alcohol	Drug	Psychological (note type)
Mother's mother			
Mother's father			
Your mother			
Mother's sister / brother (circle)			
Father's mother			
Father's father			
Your father			
Father's sister / brother (circle)			
Your brother(s) if Y, indicate # / total			
Your sisters(s) if Y, indicate # / total			

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

With family? _____ days With others (excluding family)? _____ days

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

Family? ☐-Not at all ☐-Slightly ☐-Moderately ☐-Considerably ☐-Extremely

Others? ☐-Not at all ☐-Slightly ☐-Moderately ☐-Considerably ☐-Extremely

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

Family? ☐-Not at all ☐-Slightly ☐-Moderately ☐-Considerably ☐-Extremely

Others? ☐-Not at all ☐-Slightly ☐-Moderately ☐-Considerably ☐-Extremely

Psychological / Emotional Status

How many times in your life have you received services for any psychological or emotional problems:

In a hospital or inpatient setting? _____ In an agency or private setting? _____

Do you receive financial compensation for a psychiatric or emotional disability? ☐ - Yes ☐ - No

Have you had a significant time period (not a direct result of drug/alcohol use) in which you have experienced any of the following? Indicate yes with a Y, or no with an N .

Condition	Past 30 days		Lifetime	
Serious depression – sadness, hopelessness, loss of interest, difficulty with daily functioning?	☐ - Yes	☐ - No	☐ - Yes	☐ - No
Serious anxiety/tension – uptight, unreasonably worried, unable to feel relaxed?	☐ - Yes	☐ - No	☐ - Yes	☐ - No
Hallucinations – saw things or heard voices that others did not see or hear?	☐ - Yes	☐ - No	☐ - Yes	☐ - No
Trouble understanding, concentrating, or remembering?	☐ - Yes	☐ - No	☐ - Yes	☐ - No
Trouble controlling violent behavior including having episodes of rage or violence?	☐ - Yes	☐ - No	☐ - Yes	☐ - No
Serious thoughts of suicide?	☐ - Yes	☐ - No	☐ - Yes	☐ - No
Attempted suicide?	☐ - Yes	☐ - No	☐ - Yes	☐ - No
Been prescribed medication for psychological or emotional problems?	☐ - Yes	☐ - No	☐ - Yes	☐ - No

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

How much have you been bothered have you been 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

_____ _____

Client Signature Date

University of Wyoming
Dept. of Professional Studies -
Counseling Program
Dept. 3374

Counselor Education Training Clinic

C. E. T. C.

Helping Individuals, Couples, and Families to Thrive

1000 E. University Avenue
Laramie, WY 82071
(307) 766-6820
e-mail: CETC@uwyo.edu

American Society of Addictions Medicine (ASAM)
Substance Use Assessment Dimensions

The following dimensions are used to structure information gathering as you meet with clients who are receiving a substance use evaluation, and as you review the ASI Substance Use Evaluation – Client Form. Your understanding of the client's situation and needs related to each of these dimensions will play the key role in making treatment recommendations based on the ASAM Placement Criteria. Consult *The ASAM Criteria* book in the Clinic Workroom for more detailed information about each dimension.

ASAM Assessment Dimensions:

Dimension 1: Acute Intoxication and/or Withdrawal Potential – Assesses the need for stabilization of acute intoxication, including the type and intensity of withdrawal management services needed. Clinicians should attend to current level of intoxication, any current withdrawal symptoms, and withdrawal risk based on the client's withdrawal history.

Dimension 2: Biomedical Conditions and Complications – Assesses the need for physical health services, including needs for acute stabilization and/or ongoing management for a chronic physical health condition. Clinicians should attend to any physical condition that may interfere with substance use services (including pregnancy).

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications – Assesses the need for mental health services for signs and symptoms which are at least partially independent of any substance use, or if part of a substance use concern, which require specific mental health treatment. Clinicians determine if there are conditions requiring acute, ongoing, and/or concurrent mental health treatment (including suicidal ideation). Clinicians should particularly attend to possible trauma-related, cognitive and developmental concerns.

Dimension 4: Readiness for Change – Assesses the degree to which the client recognizes the role of his/her substance use in current problems, and is willing to take action to change his/her substance use accordingly (based on Prochaska & DiClemente's stages of change model). Clinicians attend to the client's awareness of the relationship between substance use behaviors and negative life consequences, as well as how ready, willing or able the client is to make changes in substance use thinking and behaviors.

Dimension 5: Relapse, Continued Use, or Continued Problem Potential – Assesses the need for relapse prevention services. If the client has not achieved a period of recovery and wellness from which to relapse, this dimension assesses the potential for continued problematic substance use, or other ongoing problems (including mental health issues) that require services to avoid. Clinicians attend to any immediate danger of severe mental health distress or continued substance use, and the severity of negative consequences if use continues. Clinicians also attend to the client's awareness of and ability to cope with cravings and triggers to use, including the ability to manage life-stresses without resorting to impulsive substance use or impulsive harm to self/others.

Dimension 6: Recovery/Living Environment – Assess the influence (positive and/or negative) of the client's social network and living situation on continued use and engagement in services. Clinicians attend to any need for independent living skills or access to resources, the influence of family, co-workers and peers on the client's use and potential support or interference of these people with the client's recovery and ongoing physical, emotional, and social wellness.

Revised 2015 . 09

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American Society of Addictions Medicine (ASAM)
Adult Placement Criteria

Based on information from the ASI Substance Use Evaluation – Client Form and your clinical sessions with the client, consider the client's status and situation in each of the ASAM Assessment Dimensions. Using the following guidelines and your clinical judgment about each client's unique circumstances, identify the best representation of each client's level of need and recommendations for treatment (identify the appropriate level of care and recommended services within that level of care. Consult *The ASAM Criteria* book in the Clinic Workroom for more detailed descriptions of the placement decision criteria.

On the client's Closing/Transfer Summary, under "Ongoing Concerns / Future Recommendations," specify the recommended level of care (number and name), supported by details for each of the six assessment dimensions, and identify any recommended services that fit the level of care specified. Where needed, the Closing – Transfer Summary will be sent to courts or other organizations to document the client's participation in a substance use evaluation and with your professional recommendations.

ASAM Assessment Dimensions:

1. Acute Intoxication and or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral, or Cognitive Conditions and Complications
4. Readiness for Change
5. Relapse, Continued Use, or Continued Problem Potential
6. Recovery/Living Environment

Levels of Care:

Level 0 – Stable: No treatment recommendations

Level 0.5 – Early Intervention: Preventative assessment and education for clients at risk of developing substance-related or addictive behavior problems who *do not* meet the diagnostic criteria of a substance use or addictive disorder. Substance use is beginning to cause some harmful effects and/or client is engaging in high-risk use.

Characteristics by Assessment Dimension to qualify for this level of care:

1. No withdrawal risk.
2. Biomedical conditions and complications, if any, are very stable or are being actively addressed and will not interfere with therapeutic interventions.
3. Emotional, behavioral, or cognitive conditions and complications, if any, are being appropriately addressed and will not interfere with therapeutic interventions.
4. Client is willing to explore how substance use may be harmful and/or impair her/his ability to meet responsibilities and achieve goals.
5. Client needs an understanding of, or skills to change, current use patterns and/or high risk behavior.
6. The client's social support system or significant others increase his/her risk of use.

Level 1 – Outpatient Services: Outpatient services are targeted to help clients who meet diagnostic criteria for a substance use, substance-induced, and/or other addictive disorder change their substance use or addictive behaviors and/or to enhance their motivation for change through regularly scheduled sessions of typically involve fewer than 9 contact hours per week.

Characteristics by Assessment Dimension to qualify for this level of care:

1. Not experiencing significant withdrawal or at minimal risk of severe withdrawal.
2. Biomedical conditions and complications, if any, are under concurrent medical monitoring and are sufficiently stable to permit participation in outpatient services.
3. Emotional, behavioral, or cognitive conditions and complications, if any, are very stable and will not interfere with therapeutic interventions and are being addressed with concurrent mental health monitoring.
4. Client is ready for recovery but needs motivating and monitoring strategies to strengthen readiness, *OR* does not acknowledge a substance or mental health problem, but needs monitoring and motivating strategies to engage in treatment and progress through stages of change.
5. Client is able to maintain abstinence or control use, and/or addictive behaviors and pursue recovery or motivational goals with minimal support.
6. The client's recovery/living environment is sufficiently supportive for effective outpatient work and/or the client has skills to effectively cope.

Level 2.1 – Intensive Outpatient Services: Services for clients who meet diagnostic criteria for a substance use, substance-induced and/or other addictive disorder. Services generally involve between 9 and 19 hours of structured programming per week for adults, including counseling and education about substance abuse and mental health concerns, with close monitoring of and referral for any medical and/or psychiatric concerns. Any Dimension 3 concerns are addressed in Co-Occurring Capable or Co-Occurring Enhanced programs.

Characteristics by Assessment Dimension to qualify for this level of care:

1. Minimal risk of severe withdrawal manageable at this level of care.
2. Biomedical conditions and complications, if any, are stable, will not distract from treatment and are manageable at this level of care.
3. Emotional, behavioral, or cognitive conditions and complications, if any, are mild and are being monitored by a Co-Occurring Capable or Co-Occurring Enhanced program adequately at a level 2.1 setting.
4. Client has variable engagement in treatment, ambivalence, or a lack of awareness of the substance use or mental health problems, and requires a structured program several times a week to promote progress through the stages of change.
5. Intensification of symptoms *Or* lack of awareness and/or effective coping related to relapse potential (including unsuccessful treatment at a lower level of care) necessitate close monitoring and support at the IOP level.
6. The client's recovery/living environment is not supportive, but with structure and support the client can cope.

Level 2.5 – Partial Hospitalization Services: Services for clients who meet diagnostic criteria for a substance use, substance-induced and/or other addictive disorder involving 20+ hours of intensive programming per week (day treatment) but not 24-hour care. Programs typically offer direct access to psychiatric, medical and lab services and are thus able to address needs in dimensions 1-3 which warrant daily monitoring or management than lower levels of care.

Characteristics by Assessment Dimension to qualify for this level of care:

1. Moderate risk of severe withdrawal manageable at this level of care.
2. Biomedical conditions and complications, if any, are not sufficient to distract from treatment, but require medical monitoring and/or management at a level 2.5 setting.
3. Emotional, behavioral, or cognitive conditions and complications are absent, or if present are mild to moderate in severity and may potentially distract from recovery, but may be stabilized in a Co-Occurring Capable or Co-Occurring Enhanced program adequately at a level 2.5 setting.
4. Client has poor engagement in treatment, significant ambivalence, or a lack of awareness of the substance use or mental health problem, requiring a near-daily structured program or intensive engagement services to promote progress through the stages of change.
5. Intensification of addiction or mental health symptoms, despite active participation in a Level 1 or 2.1 program, indicates a high likelihood of relapse or continued use or continued problems without near-daily monitoring and support.
6. The client's recovery/living environment is not supportive, but with structure and support and relief from the home environment, the client can cope.

Additional Levels of Care are described below, but are unlikely for the client population we serve. Complete criteria for these levels of care are included in *The ASAM Criteria* book in the Clinic Workroom, which should be consulted on any questions regarding these additional levels.

Level 3.1 – Clinically Managed Low Intensity Residential Services: Live-in services with 24-hour staff availability. Provides sufficient stability to prevent or minimize relapse or continued use. At least 5 hours of clinical services per week, focused on addressing deficits in dimensions 4, 5 and 6. Interpersonal and group living skills are promoted through an emphasis on community within the residential setting.

Level 3.3 – Clinically Managed Population-Specific High Intensity Residential Services: A structured live-in service setting with high-intensity clinical services designed to meet the needs of clients with significant *cognitive impairment* (either permanent or temporary) resulting in significant functional limitations and challenges to recovery.

Level 3.5 – Clinically Managed High Intensity Residential Services: Designed to serve clients who's multidimensional needs are of such severity that they cannot safely be treated in less intensive levels of care. These individuals need safe and stable living environments in order to develop and/or demonstrate sufficient recovery skills so that they do not immediately relapse or continue to use at a dangerous level upon transfer to a less intensive level of care. Treatment

Level 3.7 – Medically Monitored Intensive Inpatient Services: Medically equipped and staffed facility for 24-hour nursing care and medical monitoring. Services are designed to meet the needs of clients with functional limitations in Dimensions 1, 2, and/or 3. Individuals whose major concerns are in Dimensions 4, 5, or 6 are better served at lower level or care or combination of care.

Level 4 – Medically Managed Intensive Inpatient Services: Services are provided in an acute care inpatient setting, and are appropriate for clients whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care by addiction-credentialed physicians and other professionals. Services are managed by a physician. Treatment is 24-hours a day and the full resources of a licensed hospital are available.

Opioid Treatment Services: Services specific to the treatment of opioid use disorders, involving both pharmacological and non-pharmacological treatment modalities daily or several times each week.

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Counselor Education Training Clinic

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Laramie, WY 82071
(307) 766-6820
e-mail: CETC@uwyo.edu

Date: Click here to enter a date.

Click here to enter text.

Re: Click here to enter text.
Of: Click here to enter text.
Date of Birth: Click here to enter text.

Click here to enter text.

This letter is to confirm that Click here to enter text. contacted the Counselor Education Training Clinic (CETC) to complete a substance use evaluation. Clients complete an Addiction Severity Index (ASI) form and several assessment sessions with a counselor. The information gathered is based on guidelines established by the American Society of Addiction Medicine (ASAM). Results of the assessment are compared against ASAM criteria to determine treatment recommendations.

Attached you will find a summary of our work with this individual, including our recommendations for any further treatment.

As always, feel free to contact us should you have additional questions.

Respectfully,

Counselor-in-Training

Clinical Supervisor

University of Wyoming
Dept. of Professional Studies -
Counseling Program
Dept. 3374

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Date: Click here to enter a date.

Click here to enter text.

Re: Click here to enter text.
Of: Click here to enter text.
Date of Birth: Click here to enter text.

Click here to enter text.

This letter is to confirm that Click here to enter text. sought services as a client at the Counselor Education Training Clinic (CETC) for the following purpose:
Click here to enter text.

We have been asked to share with you a summary of our interactions with this client.

Name of Client's counselor: Click here to enter text.
Client first contacted our office regarding services on Click here to enter a date.
Client's initial appointment was on: Click here to enter a date.
Number of schedule sessions completed as of today: Click here to enter text.
Number of cancelled sessions: Click here to enter text.
Number of sessions missed without contact: Click here to enter text.

☐ This client has successfully completed all recommendations for services.

☐ This client will need to attend additional sessions to complete all recommendations.
Estimated number of sessions remaining (at 1 session per week) to complete the purpose stated above: .
Pease note that this is just an estimate. The actual number of sessions and time needed can vary widely and depends principally on the client. In addition, the CETC is only open during the academic calendar year.

As always, feel free to contact us should you have additional questions.

Respectfully,

Counselor-in-Training

Clinical Supervisor

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Date: Click here to enter a date.

Click here to enter text.
Click here to enter text.
Click here to enter text.

Dear Click here to enter text.,

According to my records, you missed our scheduled appointment on Click here to enter a date. at Click here to enter text. , and I haven't heard from you. Since I have been unable to reach you by phone, I wanted to let you know that I will not be able to hold your time slot open unless you call me right away to schedule a new appointment. You may have decided that you are done with counseling for the time being, or things are just very busy for you right now. If either of these are true for you, please call to let me know so that I can close your file. If I haven't heard from you by Click here to enter a date., I will go ahead and close your file to keep our records up to date. Please understand that even if we close your file, you can always come back at any time and meet with me or with another counselor. You just need to give us a call (766-6820).

As always, feel free to contact me if you have any questions.

Respectfully,

Counselor-in Training

Clinical Supervisor

Community Resources:

Peak Wellness Center: 745-8914 (Regular and after hours emergency line)
Ivinson Memorial Hospital: 742-0285 (Emergency Services)
UW Counseling Center (UCC): 766-2187 (After-hours crisis line – 766-5179)
SAFE Project: 742-7273
Youth Crisis: 742-5936
Family Violence and Sexual Assault: 745-3556

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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

Clinical Documentation Timeline

Below are listed the documentation tasks / items that should be completed during or after the session – before the next scheduled session

Session 1:

Client Information
Consent to Receive Services (Assent if a child client)
2 complete copies, a signed copy for the file and a copy for the client
SRS/ORS scores recorded on SRS/ORS Scores Plot, discussed with client
Consent to Bilateral Release (if necessary)
Mental Status Exam Checklist
Session Note
Intake Summary

Session 2:

SRS/ORS scores recorded on SRS/ORS Scores Plot, discussed with client
Session Note

Session 3:

Counseling Service Plan
The service plan must be reviewed with the client, and a new service plan form filled out every four weeks from the date of the original service plan
SRS/ORS scores recorded on SRS/ORS Scores Plot, discussed with client
Session Note

Every Other Session

SRS/ORS scores recorded on SRS/ORS Scores Plot, discussed with client
Session Note
For all sessions and no-shows
Contact Note
One for each time you have contact with the client outside of a session, or the client calls and leaves a message for you (including cancelled or rescheduled sessions), and each time you have contact with someone other than the client (as permitted by the Consent to Release of Information), or with a parent/guardian in the case of services to a minor.
Clinical Interview – ASI, ASAM Placement Summary, Letters
As needed per client needs, after the session in which the information was obtained / completed

Final Session:

Closing or Transfer Summary
Move ORS/SRS Scores Plot to bottom right in chart

Client File Organization

Documents are listed as they should appear in the client chart, top to bottom (items listed first belong on the top).

Left Side

SRS/ORS Scores Plot
Moves to bottom of right side when closing file

Client Information
Be sure it includes address, phone number and date of birth

Consent to Receive Services
Disclosure & informed consent; must be signed by the client, counselor and supervisor

Child Assent to Receive Services
If applicable

MSE Checklist

Request for Services Form

Consent to Bilateral Release of Information

Consent for Research Participation

ASI/ASAM Letters sent Out
Stamped "Copy/Faxed/Mailed"

ASAM Placement Summary

Clinical Interview - ASI

Other letters sent out (non-ASI)

Materials Received from Others

Right Side

Closing / Transfer Summary

Notes
Reverse Chronological (oldest on bottom); one note for very session, no-show, reschedule, cancellation, contact, or other phone call related to the case

Service Plans / Reviews
Integrated with the notes, as they fit chronologically into the service sequence

Intake Summary
Integrated with the notes

(SRS/ORS Scores Plot)
Moved here upon closing with the client

Sample Sequence for Closed File

Closing / Transfer Summary
Session Note – 6th Session
Session Note – 5th Session
Contact Note – Phone call, reschedule
Session Note – 4th Session
Service Plan
Session Note – 3rd Session
Session Note – 2nd Session
Session Note – No-Show
Intake Summary
Session Note – 1st Session
SRS/ORS Scores Plot

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: _____

Date / Week	Direct Client Contact	Supervision			Other Indirect (prep, notes, research)	Weekly Totals
		Individual / Triadic	Group: Site / Block	UW Class		
Totals						

Signatures:

_____ _____
Student Date

_____ _____
Individual / Triadic Supervisor Date

_____ _____
UW Course Instructor Date

Revised 2010 . 08

University of Wyoming – Professional Studies - Counseling

Counseling Student's Clinical Log - Summary

Counseling Student:

Dates Enrolled in UW Counselor Education Program:

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

Semester, Year	Clinical Site or Course	Direct Client Contact	Individual / Triadic supervision	Group Supervision	Other Indirect Hours	Totals
Totals						

Student Signature Date

Counseling Program Faculty Signature Date

Counseling Skills Evaluation Form: MS Version

University of Wyoming, Department of Professional Studies, Counseling Program

Student: _____ **Instructor:** _____

Triad Spvsr: _____ **Block Spvsr:** _____

Course / Semester: ☐ Pre-Practicum / Fall ☐ Practicum / Spring Year: _____

Instructions: Rate yourself / the trainee on each item by circling *only one* number or letter completely (nothing in-between). Supervisors consult with instructors to arrive at a consensus rating for each item. Some rating options reflect a developmental course for the item, and developmental considerations should be applied. On non-developmental items, the expectation is that trainees will fully meet professional expectations early in the fall semester. Circle "no-information" only when there really is *no* information at all. Both the trainee and supervisors should also list strengths and growth areas, plus specific plans for addressing growth areas.

N = No Information; **0** = Unacceptable Performance; **1** = Below Pre-Prac Mastery Level; **2** = Pre-Prac Mastery; **3** = Between Pre-Prac and Prac Mastery Level; **4** = Practicum Mastery Level (Ready for Internship)

or

N = No Information; **U** = Unacceptable Performance; **P** = Progressing; **M** = Meets Expectations

Core Counseling Skills:		**Mid-Term**	**Final**
1 Therapeutic Relationship: 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. Appropriate pacing.	Student	N 0 1 2 3 4	N 0 1 2 3 4
	Supervisors	N 0 1 2 3 4	N 0 1 2 3 4
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.	Student	N 0 1 2 3 4	N 0 1 2 3 4
	Supervisors	N 0 1 2 3 4	N 0 1 2 3 4
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).	Student	N 0 1 2 3 4	N 0 1 2 3 4
	Supervisors	N 0 1 2 3 4	N 0 1 2 3 4
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.	Student	N 0 1 2 3 4	N 0 1 2 3 4
	Supervisors	N 0 1 2 3 4	N 0 1 2 3 4
5 Assessment: Ability to clarify the client's presenting problem (scope, dynamics, intensity, attempted solutions, the 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.	Student	N 0 1 2 3 4	N 0 1 2 3 4
	Supervisors	N 0 1 2 3 4	N 0 1 2 3 4

		Mid-Term	Final
6 Diagnosis: Demonstrates the ability to articulate a meaningful, accurate description of clients' symptoms, mental functioning and behavior to guide effective services (considering both strengths and vulnerabilities across biological, psychological, and social domains). Appropriately uses diagnostic tools, including the current edition of the *DSM*. Is able to conceptualize an accurate diagnosis of disorders presented by the client and discuss the differential diagnosis with other professionals.	Student	N 0 1 2 3 4	N 0 1 2 3 4
	Supervisors	N 0 1 2 3 4	N 0 1 2 3 4
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.	Student	N 0 1 2 3 4	N 0 1 2 3 4
	Supervisors	N 0 1 2 3 4	N 0 1 2 3 4
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.	Student	N 0 1 2 3 4	N 0 1 2 3 4
	Supervisors	N 0 1 2 3 4	N 0 1 2 3 4

Conceptual Skills:		Mid-Term	Final
9 Knowledge-Base: Has adequate understanding of counseling techniques, general client dynamics, information related to a variety of presenting concerns, diagnostic criteria, potential interventions. Draws on knowledge-base of field to understand clients and guide effective service delivery.	Student	N 0 1 2 3 4	N 0 1 2 3 4
	Supervisors	N 0 1 2 3 4	N 0 1 2 3 4
10 Theoretical Development: Is developing a personal approach to counseling based on a sound, intentional rationale grounded in the literature, 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.	Student	N 0 1 2 3 4	N 0 1 2 3 4
	Supervisors	N 0 1 2 3 4	N 0 1 2 3 4
11 Case Conceptualization: Can generate a variety of meaningful, theory-based 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.	Student	N 0 1 2 3 4	N 0 1 2 3 4
	Supervisors	N 0 1 2 3 4	N 0 1 2 3 4

Professionalism Skills:		Mid-Term	Final
12 Professional Conduct: Professional dress; punctuality (on time to start/end sessions, 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. Thoughtfully accepts other's feedback. Communicates respect for others' perspectives in words and actions. Resolves differences and conflict with colleagues in a professional, respectful manner.	Student	N U P M	N U P M
	Supervisors	N U P M	N U P M
13 Ethical Practice: Demonstrates the ability to apply and adhere to ethical and legal standards in all professional activities.	Student	N U P M	N U P M

		Mid-Term	Final
	Supervisors	N U P M	N U P M
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.	Student	N U P M	N U P M
	Supervisors	N U P M	N U P M
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.	Student	N U P M	N U P M
	Supervisors	N U P M	N U P M
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.	Student	N 0 1 2 3 4	N 0 1 2 3 4
	Supervisors	N 0 1 2 3 4	N 0 1 2 3 4

Personal Management:		Mid-Term	Final
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.	Student	N U P M	N U P M
	Supervisors	N U P M	N U P M
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 (ongoing self-reflection). Willing to self-confront and grow. Is not defensive about feedback. Willing to seek help for personal awareness and growth when appropriate.	Student	N U P M	N U P M
	Supervisors	N U P M	N U P M
19 Tolerance For Vulnerability & 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.	Student	N 0 1 2 3 4	N 0 1 2 3 4
	Supervisors	N 0 1 2 3 4	N 0 1 2 3 4
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.	Student	N U P M	N U P M
	Supervisors	N U P M	N U P M

Mid-Term Comments

Student:

Strengths: _____

_____

_____

_____

_____

Growth Areas: _____

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_____

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_____

Block Supervisor:

Strengths: _____

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Growth Areas: _____

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Triadic / Individual Supervisor:

Strengths: _____

_____

_____

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Growth Areas: _____

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_____	_____	_____	_____
Student Signature	Date	Block Supervisor	Date
		_____	_____
		Individual / Triadic Supervisor	Date

End-of-Term Comments

Student:

Strengths: _____

Growth Areas: _____

Block Supervisor:

Strengths: _____

Growth Areas: _____

Triadic / Individual Supervisor:

Strengths: _____

Growth Areas: _____

Student – Based on the information above, work with your supervisors to identify and list some specific, measurable plans for the your continued professional (clinical skill) and personal (self-awareness and self-management) growth:

Professional: 1 _____

_____

_____

2 _____

_____

_____

Personal: 1 _____

_____

_____

2 _____

_____

_____

_____ _____

Student Signature Date

_____ _____

Block Supervisor Date

_____ _____

Individual/Triadic Supervisor Date

Counseling Skills Evaluation Form: Ph.D. Version

University of Wyoming, Department of Professional Studies, Counseling Program

Student: _____

Faculty Spvsr: _____ **Instructor:** _____

Semester: ☐ Fall ☐ Spring ☐ Summer Year: _____

Course: ☐ Doc Practicum ☐ Internship ☐ Other: _____

Instructions: Rate yourself / the trainee on each item by circling *only one* number or letter completely (nothing in-between). Some rating options reflect a developmental course for the item, and developmental considerations should be applied. On non-developmental items, the expectation is that trainees will fully meet professional expectations early in the fall semester. Circle "no-information" only when there really is *no* information at all. Both the trainee and supervisor should also list strengths and growth areas, plus specific plans for addressing those growth areas.

N = No Information; **0** = Unacceptable Performance; **1** = Below PhD Mastery Level; **2** = PhD Mastery Level

or

N = No Information; **U** = Unacceptable Performance; **P** = Progressing; **M** = Meets Expectations

Core Counseling Skills:		**Mid-Term**	**Final**
1 Therapeutic Relationship: 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. Appropriate pacing.	Student	N 0 1 2	N 0 1 2
	Triad SPV	N 0 1 2	N 0 1 2
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.	Student	N 0 1 2	N 0 1 2
	Triad SPV	N 0 1 2	N 0 1 2
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).	Student	N 0 1 2	N 0 1 2
	Triad SPV	N 0 1 2	N 0 1 2
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.	Student	N 0 1 2	N 0 1 2
	Triad SPV	N 0 1 2	N 0 1 2
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.	Student	N 0 1 2	N 0 1 2
	Triad SPV	N 0 1 2	N 0 1 2

			Mid-Term	Final
6	Diagnosis: Demonstrates the ability to articulate a meaningful, accurate description of clients' symptoms, mental functioning and behavior to guide effective services (considering both strengths and vulnerabilities across biological, psychological, and social domains). Appropriately uses diagnostic tools, including the current edition of the *DSM*. Is able to conceptualize an accurate diagnosis of disorders presented by the client and discuss the differential diagnosis with other professionals.	Student	N 0 1 2	N 0 1 2
		Triad SPV	N 0 1 2	N 0 1 2
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.	Student	N 0 1 2	N 0 1 2
		Triad SPV	N 0 1 2	N 0 1 2
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.	Student	N 0 1 2	N 0 1 2
		Triad SPV	N 0 1 2	N 0 1 2

Conceptual Skills:			Mid-Term	Final
9	Knowledge-Base: Has adequate understanding of counseling techniques, general client dynamics, information related to a variety of presenting concerns, diagnostic criteria, potential interventions. Draws on knowledge-base of field to understand clients and guide effective service delivery.	Student	N 0 1 2	N 0 1 2
		Triad SPV	N 0 1 2	N 0 1 2
10	Theoretical Development: Is developing a personal approach to counseling based on a sound, intentional rationale grounded in the literature, 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.	Student	N 0 1 2	N 0 1 2
		Triad SPV	N 0 1 2	N 0 1 2
11	Case Conceptualization: Can generate a variety of meaningful, theory-based 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.	Student	N 0 1 2	N 0 1 2
		Triad SPV	N 0 1 2	N 0 1 2

Professionalism Skills:			Mid-Term	Final
12	Professional Conduct: Professional dress; punctuality (on time to start/end sessions, 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. Thoughtfully accepts other's feedback. Communicates respect for others' perspectives in words and actions. Resolves differences and conflict with colleagues in a professional, respectful manner.	Student	N U P M	N U P M
		Triad SPV	N U P M	N U P M
13	Ethical Practice: Demonstrates the ability to apply and adhere to ethical and legal standards in all professional activities.	Student	N U P M	N U P M

			Mid-Term	Final
		Triad SPV	N U P M	N U P M
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.	Student	N U P M	N U P M
		Triad SPV	N U P M	N U P M
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.	Student	N U P M	N U P M
		Triad SPV	N U P M	N U P M
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.	Student	N 0 1 2	N 0 1 2
		Triad SPV	N 0 1 2	N 0 1 2

Personal Management:			Mid-Term	Final
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.	Student	N U P M	N U P M
		Triad SPV	N U P M	N U P M
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.	Student	N 0 1 2	N 0 1 2
		Triad SPV	N 0 1 2	N 0 1 2
19	Tolerance For Vulnerability & 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.	Student	N 0 1 2	N 0 1 2
		Triad SPV	N 0 1 2	N 0 1 2
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.	Student	N U P M	N U P M
		Triad SPV	N U P M	N U P M

Mid-Term Comments

Student:

Strengths: _____

Growth Areas: _____

Triadic / Individual Supervisor:

Strengths: _____

Growth Areas: _____

Student Signature	Date	Block Supervisor	Date
		Individual / Triadic Supervisor	Date

End-of-Term Comments

Student:

Strengths:

Growth Areas:

Triadic / Individual Supervisor:

Strengths:

Growth Areas:

Student – Based on the information above, work with your supervisors to identify and list some specific, measurable plans for the your continued professional (clinical skill) and personal (self-awareness and self-management) growth:

Professional: 1 _____

_____

_____

2 _____

_____

_____

Personal: 1 _____

_____

_____

2 _____

_____

_____

_____ _____

Student Signature Date

_____ _____

Block Supervisor Date

_____ _____

Individual/Triadic Supervisor Date

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.

Counselor Name:			Supervisor Name:	

		Not Observed	Not Effective	Effective	Very Effective
1	Helps create a safe environment				
2	Structures supervision sessions				
3	Provides useful feedback				
4	Encourages my active involvement				
5	Is available and accessible				
6	Encourages questions				
7	Helps me understand client dynamics				
8	Supports me				
9	Challenges me to grow				
10	Helps me look at my own issues				
11	Provides helpful suggestions				
12	Is flexible and open				
13	Is fair and respectful				
14	Helps me address ethical issues				
15	Helps me with client documentation				
16	Is multiculturally responsive				
17	Invites self-reflection / evaluation				
18	Seeks my ideas and input				
19	Helps me consider my own theory				

Adapted from Campbell, J. M. (2000). *Becoming an effective supervisor: A workbook*. : A workbook. Routledge/Taylor & Francis Books.

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: _____

Revised 2012 . 04

Block Feedback Form

For use in UW Counseling Program

Do not put your names on this form.

Counselors, Please take a minute or two to provide feedback on how things are going in your block. Your honest feedback will enable us to help your block supervisor to provide you a more effective and useful block experience. These individual sheets will not be shared with your block supervisor; they will receive an aggregate of your responses.

Block (Day-Time): _____

1. What do you think went well in your block? (please be as specific as possible)

2. What do you wish your supervisor had done differently in block?

3. What do you think could be changed about how block is structured and run that would improve future students' development as counselors (think broadly here)?

Reflective Self-Supervision Form

Name: Your Name. Date: Date of Session

Identify a section from your session that you are unsure about, uncomfortable with, or that in any other way deserves some supervision time. As you watch it and think about your in-class staffing, reflect on the following questions and then write your answers to them. Base your reflection and answers on what came up in *you* during the session, your contribution to what was going on, and how a better understanding of yourself may help you identify areas for personal growth and improve how you think, feel, act and relate in the future. Turn in a copy to your instructor in class the week after your staffing.

1. Consider your counselor presence with the client and any internal distractions:

   What were you **thinking** and **feeling** at that time (about yourself, the client, the session, other)?

   Thinking & Feeling.

   How did your thoughts and feelings impact what you did and how you related to your client?

   Impact of thoughts & feelings on your doing & relating.

2. As you reflect on the segment, identify where the thoughts, feelings and reactions you had came from. In particular, try to identify any unhelpful things that were influencing how you thought, felt and reacted to the client – think of pressures, your habitual coping strategies, family of origin rules, and so forth. Describe the link between these external/internal influences and what you thought, felt, and did in session.

   Influences & impact of influences on thoughts, feelings and actions.

3. How, *specifically*, will your reflections here influence your next sessions with this and other clients? Consider not only what you'll do in session, but what you might do out of session to deepen your self-awareness and your ability to self-regulate in healthy ways (limit the impact of unhelpful influences on the way you think, feel, and react to your clients).

   Growth from reflection.

University of Wyoming
Dept. of Professional Studies -
Counseling Program
Dept. 3374

Counselor Education Training Clinic

C. E. T. C.

Helping Individuals, Couples, and Families to Thrive

1000 E. University Avenue
Laramie, WY 82071
(307) 766-6820
e-mail: CETC@uwyo.edu

Supervision Note

Supervisor: _____

Supervisee: _____ Date: _____

Clients:

Client Initials		Discussed Progress?	Viewed Recording?	Reviewed Documentation?	Safety Concerns? If yes, elaborate below
1.		Y N N/A	Y N N/A	Y N N/A	N Y
	Notes:				
2.		Y N N/A	Y N N/A	Y N N/A	N Y
	Notes:				
3.		Y N N/A	Y N N/A	Y N N/A	N Y
	Notes				
4.		Y N N/A	Y N N/A	Y N N/A	N Y
	Notes:				

Supervisee Focus:

TAP 21-A Areas - Check all which were part of today's supervision

Foundation Areas

- ☐ Theories, Roles & Modalities of Supervision
- ☐ Leadership
- ☐ Supervisory Alliance
- ☐ Critical Thinking
- ☐ Organizational Management & Administration

Performance Domains

- ☐ Counselor Development
- ☐ Professional and Ethical Standards
- ☐ Program Development & Quality Assurance
- ☐ Performance Evaluation
- ☐ Administration

Supervisee Skill Review:

	Discussed	Not Discussed	Meets Expectations	Needs Improvement	Comments
Executive Skills					
Therapeutic Relationship					
Session Management					
Communication Skills					
Intake					
Assessment					
Diagnosis					
Treatment Planning & Execution					
Appropriate Use of Self					
Conceptual Skills					
Knowledge-Base					
Theoretical Orientation					
Case Conceptualization					
Professional Skills					
Professional Conduct					
Ethical Practice					
Supervision					
Documentation					
Multicultural Competence					
Personal Management					
Appropriate Boundaries					
Self-Awareness and Growth					
Tolerance for Vulnerability & Risk					
Appropriate Self Care					

Supervisee Progress / Growth: _____

_____

_____

Supervisee Growth Areas / Assignments (executive, conceptual, professional, personal):

_____

_____

_____

_____ _____ _____ _____

Supervisor Signature Date Supervisee Signature Date

Weekly Supervision Report

Date: _____

Supervisee: _____ Prac. Instructor: _____

☐ Block
☐ Indiv/Triad

Supervisor: _____

Core Counseling Skills: ☐ No Concerns _____

Professionalism: ☐ No Concerns _____

Supervisee improvement since last week: 1 2 3 4 5 1 = worse, 3 = no change; 5 = much better

Leeds Alliance in Supervision Scale (LASS)

Place a mark on the lines to indicate how you feel about your supervision session.

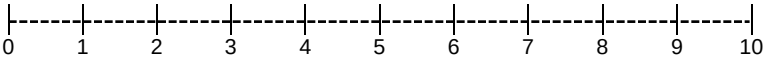
Please be as honest as possible – your supervisor won't be offended by anything you share, but will use the information to better meet your needs.

Approach

This supervision session was not focused.

This supervision session was focused.

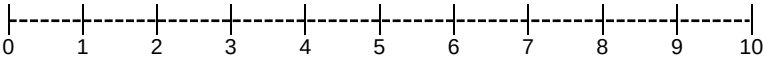
Relationship



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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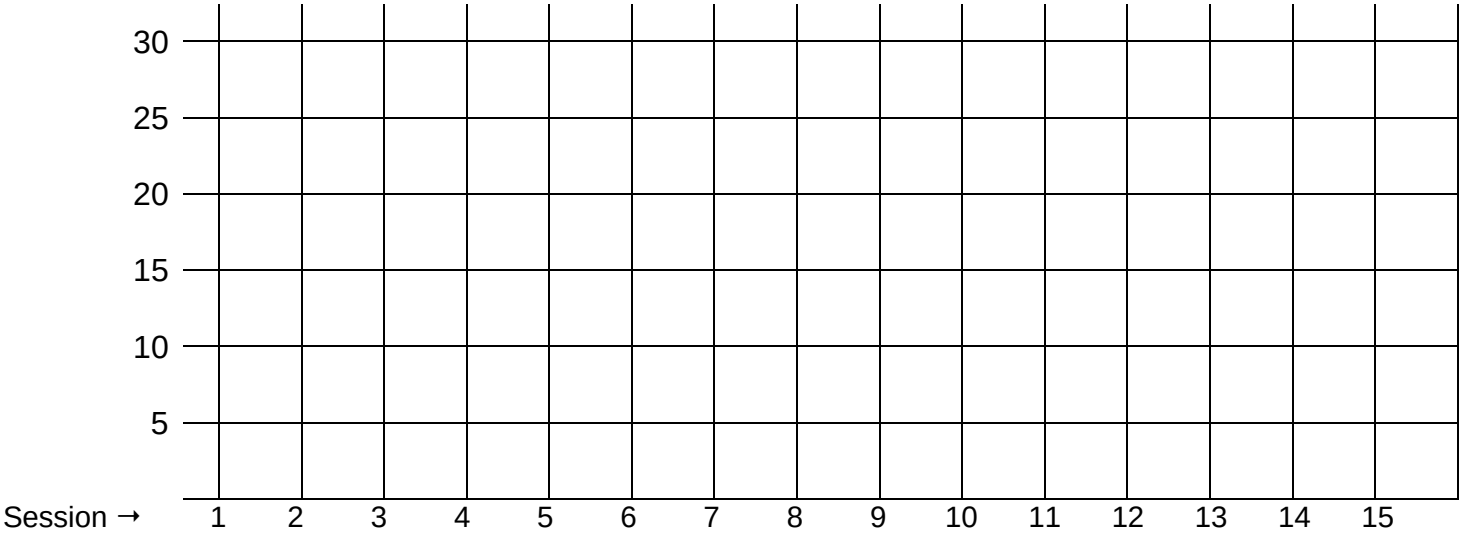
Leeds Alliance in Supervision Plot

Supervisee 1 Name: _____ **First Session Date:** _____

Supervisee 2 Name: _____ **Final Session Date:** _____

Supervisor Name: _____

Supervisor: each week after your supervisee has filled out the LASS rating sheet, plot the summed scores on the chart below, and discuss with your supervisee her/his ratings, seeking understanding about what is working well and could potentially be amplified, as well as what is not working well and which might be modified. Also discuss with the supervisee trends across supervision sessions. Because the point here is to use these scores as an invitation to discuss ways to improve the supervisory alliance, merely obtaining and plotting the scores is insufficient.



Key: Supervisee 1: —×———×—

Supervisee 2: ---●-------●----

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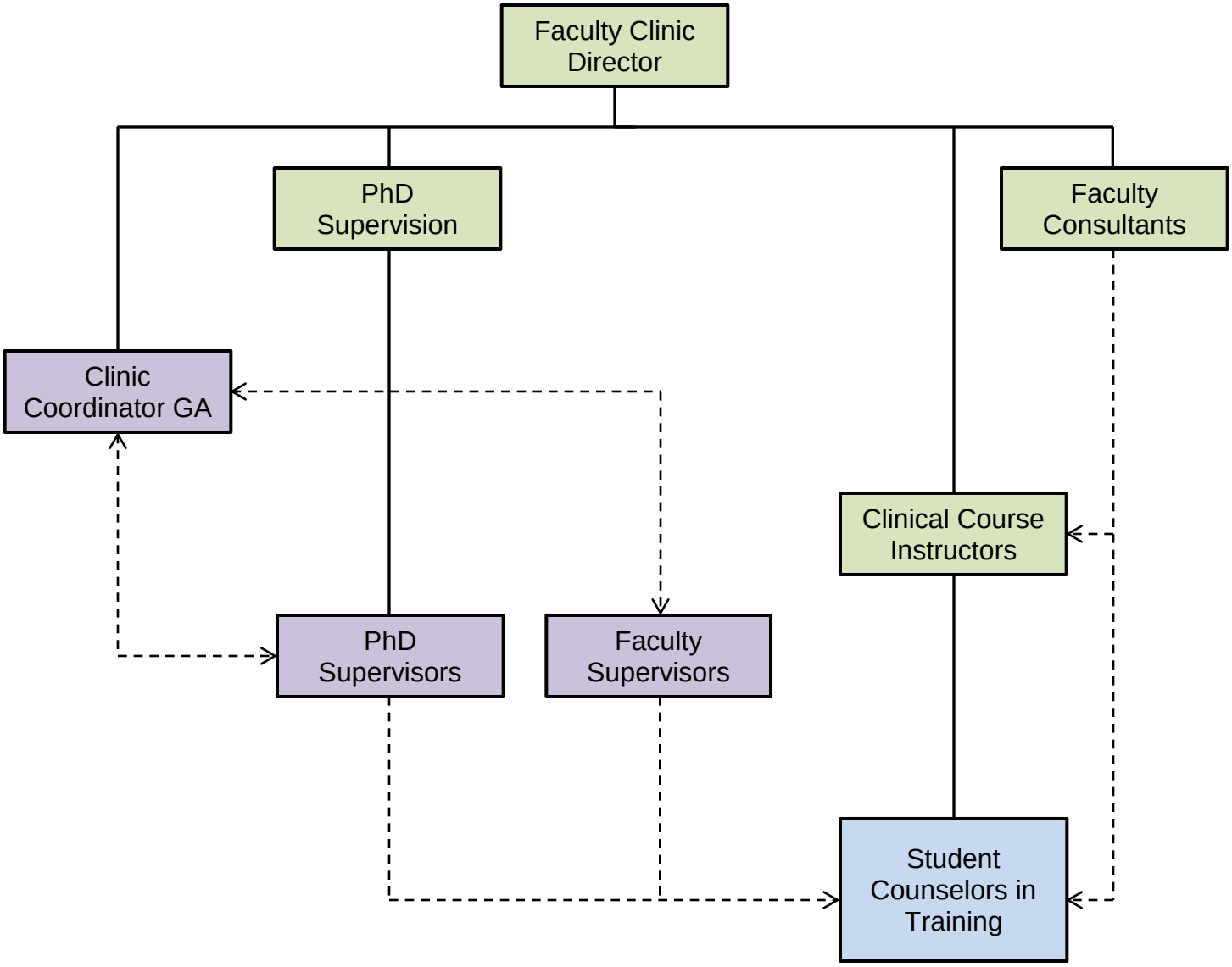
Organizational Chart



Revised 2012 04