

START INITIAL CONSULTATION REPORT

STORY

Referral source:

Reason for referral

What has motivated the client to come?

Presenting problem

Focus on one or more of the following: trigger/why now?, behavioral/functional problems, precipitating factors, developmental stage/social clock, role change, services sought, previous experience, conditions when problem improves/worsens, duration, etc. *NOTE: Record level of severity next to abnormal findings—1 (mild), 2 (moderate), or 3 (severe); use "X" if normal finding.*

Stressors	Birth of a child	Change of residence	Child leaving	Chronic health problems
	Death of a family member	Divorce	Financial problems	Major illness/disability
	Parent-child problems	Separation	Unemployment	Workplace change
	Marital problems			
Duration	Temporary	Permanent		
Frequency	/day	/week	/month	/year
Locus of control	Internal	External		

Client expectations

What does the client hope to gain from counseling?

Relevant family factors

Family dynamics, rules, values, discipline, boundaries, early development, and/or anything unusual regarding family relationships, communication, and/or family medical history:

Career/educational highlights:

Spirituality/religion:

Does the client express willingness to incorporate faith into counseling?

 YES NO

Present religious affiliation:

Spiritual/religious upbringing or practices: (denomination, patterns, rules, experiences, etc.):

Current spiritual/religious commitment:

Spirituality/religion	Unable to rate	None	Minimal	Some	Moderate	Significant	Potential level at termination
Importance	0	1	2	3	4	5	
Influence on daily activities & life	0	1	2	3	4	5	
Practice of spiritual discipline	0	1	2	3	4	5	
Spiritual maturity	0	1	2	3	4	5	

THERAPEUTIC ALLIANCE

Initial session rating	<input type="checkbox"/>	Strong	<input type="checkbox"/>	Average	<input type="checkbox"/>	Strained	<input type="checkbox"/>	Weak	<input type="checkbox"/>	None
Client self-disclosure	<input type="checkbox"/>	Strong	<input type="checkbox"/>	Average	<input type="checkbox"/>	Minimum	<input type="checkbox"/>	Initial	<input type="checkbox"/>	None
Client resistance	<input type="checkbox"/>	Strong	<input type="checkbox"/>	Average	<input type="checkbox"/>	Minimum	<input type="checkbox"/>	Initial	<input type="checkbox"/>	None
Therapeutic alliance	<input type="checkbox"/>	Appropriate	<input type="checkbox"/>	Defensive	<input type="checkbox"/>	Dependent	<input type="checkbox"/>	Domineering	<input type="checkbox"/>	Evasive
	<input type="checkbox"/>	Hostile	<input type="checkbox"/>	Passive	<input type="checkbox"/>	Seductive	<input type="checkbox"/>	Other	<input type="checkbox"/>	

List one to three client strengths evident in this session.

1.

2.

3.

List characteristics or attitudes that may impact the alliance or counseling progress.

ASSESSMENT

Current functioning

Categories	IMPAIRMENT LEVEL (select one)					Impairment Level after Treatment
	None	Mild	Moderate	Marked	Extreme	
Marriage/relationship/family/ job/school/performance	1	2	3	4	5	
____ Disability leave	1	2	3	4	5	
____ Job jeopardy						
Friendships/peer relationships	1	2	3	4	5	
Financial situation	1	2	3	4	5	
Hobbies/interests/play activities	1	2	3	4	5	
Physical health	1	2	3	4	5	
Activities of daily living (personal hygiene, bathing, etc.)	1	2	3	4	5	
Eating habits						
Weight loss ____ lbs.	1	2	3	4	5	
Weight gain ____ lbs.						
Current weight ____ lbs.						
Sleeping habits						
____ Difficulty falling asleep	1	2	3	4	5	
____ Difficulty staying asleep						
____ Early morning awakening						
Sexual functioning	1	2	3	4	5	
Spiritual/religious activities	1	2	3	4	5	
Ability to concentrate	1	2	3	4	5	
Ability to control temper	1	2	3	4	5	

Elaboration:

Symptoms

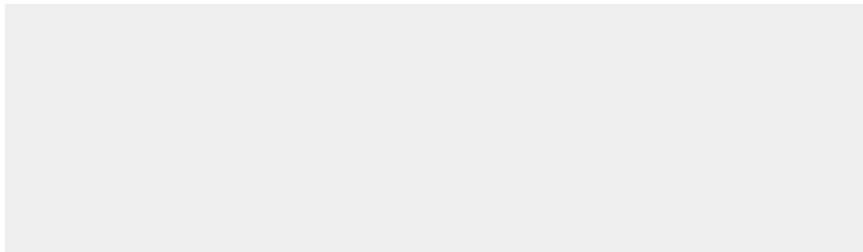
Record level of severity next to abnormal findings—1 (mild), 2 (moderate), or 3 (severe); use "X" if normal finding.

Physical	<input type="checkbox"/> N/A	Aches & pains	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>
		Headaches	<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>
		Pregnancy	<input type="checkbox"/>	Frequent illness	<input type="checkbox"/>	Sleeping problems	<input type="checkbox"/>	Trembling	<input type="checkbox"/>
Cognitive	<input type="checkbox"/> N/A	Distractibility	<input type="checkbox"/>	Disorientation	<input type="checkbox"/>	Recurring thoughts	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>
Emotional	<input type="checkbox"/> N/A	Grief	<input type="checkbox"/>	Guilt	<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	Insecurity	<input type="checkbox"/>
		Loneliness	<input type="checkbox"/>	Mood shifts	<input type="checkbox"/>	Phobias/fears	<input type="checkbox"/>	Worrying	<input type="checkbox"/>
		Apathy	<input type="checkbox"/>						
Behavioral	<input type="checkbox"/> N/A	Antisocial	<input type="checkbox"/>	Avoiding	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>
		Impulsivity	<input type="checkbox"/>	Learning disability	<input type="checkbox"/>	Speech problems	<input type="checkbox"/>	Withdrawing	<input type="checkbox"/>
Cultural	<input type="checkbox"/> N/A	Conforming	<input type="checkbox"/>	Dissonance	<input type="checkbox"/>	Resistance & immersion	<input type="checkbox"/>	Introspection	<input type="checkbox"/>
		Integration awareness	<input type="checkbox"/>						
Coping ability	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Resilient	<input type="checkbox"/>	Exhausted	<input type="checkbox"/>	Overwhelmed	<input type="checkbox"/>
		Deficient supports	<input type="checkbox"/>	Deficient skills	<input type="checkbox"/>	Growing	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>
Skill deficit	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Intellect/education	<input type="checkbox"/>	Communication	<input type="checkbox"/>	Interpersonal	<input type="checkbox"/>
		Decision making	<input type="checkbox"/>	Self-control	<input type="checkbox"/>	Self-care	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>
Risk factors	<input type="checkbox"/> Assessed <input type="checkbox"/> Legally Reportable	Child neglect	<input type="checkbox"/>	Elder neglect	<input type="checkbox"/>	Poverty	<input type="checkbox"/>	Domestic violence	<input type="checkbox"/>
		Physical abuse	<input type="checkbox"/>	Sexual abuse/molestation	<input type="checkbox"/>	Verbal/emotional abuse	<input type="checkbox"/>		<input type="checkbox"/>
Substance use/abuse	<input type="checkbox"/> N/A	Tobacco	<input type="checkbox"/>	Caffeine	<input type="checkbox"/>	Drug	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>
		Early partial remission	<input type="checkbox"/>	Early full remission	<input type="checkbox"/>	Sustained full remission	<input type="checkbox"/>	Sustained partial remission	<input type="checkbox"/>
			<input type="checkbox"/>	Early full remission	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
			<input type="checkbox"/>		<input type="checkbox"/>			<input type="checkbox"/>	

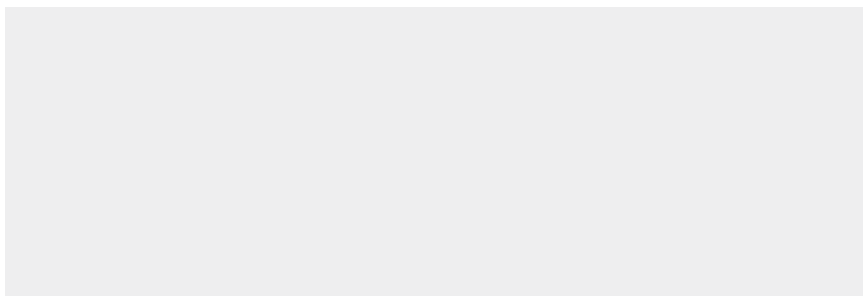
Elaboration:

Medical History

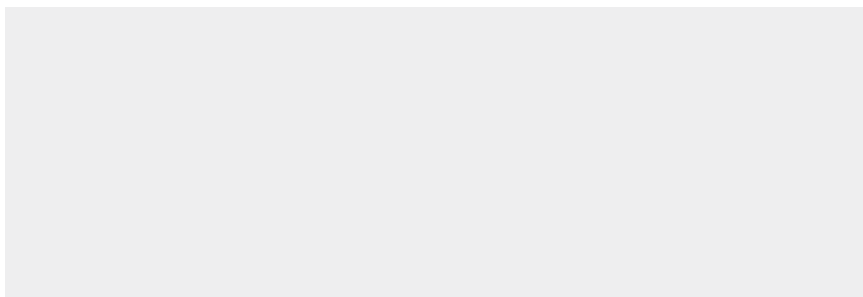
Medications (include medical, psychiatric, over-the-counter/herbal):



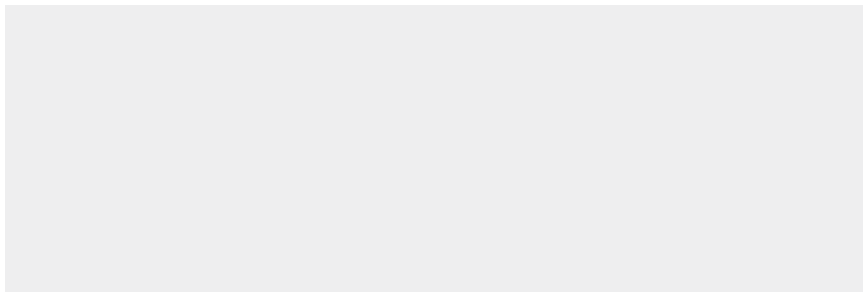
Previous therapy (purpose, counselor/psychologist/pastor, when, duration, outcome):



Recent physical exam & results:



Hospitalization (when, reason, duration):



Mental status exam

Record level of severity next to abnormal findings—

1 (mild), 2 (moderate), or 3 (severe); use "X" if normal finding.

General observations	Appearance	<input type="checkbox"/>	Well groomed	<input type="checkbox"/>	Unkempt	<input type="checkbox"/>	Disheveled	
	Build	<input type="checkbox"/>	Average	<input type="checkbox"/>	Thin	<input type="checkbox"/>	Overweight	
	Demeanor	<input type="checkbox"/>	Average	<input type="checkbox"/>	Hostile	<input type="checkbox"/>	Mistrustful	
		<input type="checkbox"/>	Withdrawn	<input type="checkbox"/>	Preoccupied	<input type="checkbox"/>	Demanding	
	Eye contact	<input type="checkbox"/>	Average	<input type="checkbox"/>	Avoidant	<input type="checkbox"/>	Intense	
	Activity	<input type="checkbox"/>	Average	<input type="checkbox"/>	Agitated	<input type="checkbox"/>	Slowed	
	Speech	<input type="checkbox"/>	Clear	<input type="checkbox"/>	Slurred	<input type="checkbox"/>	Rapid	
<input type="checkbox"/>		Pressured						
Thought content	Delusions <input type="checkbox"/> None reported	<input type="checkbox"/>	Grandiose	<input type="checkbox"/>	Persecutory	<input type="checkbox"/>	Somatic	
		<input type="checkbox"/>	Bizarre	<input type="checkbox"/>	Nihilistic	<input type="checkbox"/>	Religious	
	Other <input type="checkbox"/> None reported	<input type="checkbox"/>	Autistic	<input type="checkbox"/>	Obsessional	<input type="checkbox"/>	Phobic	
		<input type="checkbox"/>	Guilty	<input type="checkbox"/>	Ideas of reference	<input type="checkbox"/>	Preoccupied	
	Self-Abuse <input type="checkbox"/> None reported	<input type="checkbox"/>	Suicidal	<input type="checkbox"/>	Intent	<input type="checkbox"/>	Lethal	
		<input type="checkbox"/>	Self-mutilation	<input type="checkbox"/>	Means	<input type="checkbox"/>	Plan	
	Aggressive <input type="checkbox"/> None reported	<input type="checkbox"/>	Homicidal	<input type="checkbox"/>	Intent	<input type="checkbox"/>	Lethal	
<input type="checkbox"/>			<input type="checkbox"/>	Means	<input type="checkbox"/>	Plan		
Perception	Hallucinations <input type="checkbox"/> None reported	<input type="checkbox"/>	Auditory	<input type="checkbox"/>	Visual	<input type="checkbox"/>	Olfactory	
		<input type="checkbox"/>	Gustatory	<input type="checkbox"/>	Tactile			
	Other <input type="checkbox"/> None reported	<input type="checkbox"/>	Illusions	<input type="checkbox"/>	Depersonalization	<input type="checkbox"/>	Derealization	
		<input type="checkbox"/>						
Thought process	<input type="checkbox"/>	Logical	<input type="checkbox"/>	Circumstantial	<input type="checkbox"/>	Tangential	<input type="checkbox"/>	Loose
	<input type="checkbox"/>	Racing	<input type="checkbox"/>	Incoherent	<input type="checkbox"/>	Concrete	<input type="checkbox"/>	Blocked
	<input type="checkbox"/>	Flight of ideas						
Judgment	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Street-smart	<input type="checkbox"/>	Naive	<input type="checkbox"/>	Impaired
Mood	<input type="checkbox"/>	Euthymic	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Anxious	<input type="checkbox"/>	Angry
	<input type="checkbox"/>	Euphoric	<input type="checkbox"/>	Irritable				
Affect	<input type="checkbox"/>	Full	<input type="checkbox"/>	Constricted	<input type="checkbox"/>	Flat	<input type="checkbox"/>	Inappropriate
	<input type="checkbox"/>	Liable						
Behavior	<input type="checkbox"/>	Cooperative	<input type="checkbox"/>	Resistant	<input type="checkbox"/>	Agitated	<input type="checkbox"/>	Impulsive
	<input type="checkbox"/>	Oversedated	<input type="checkbox"/>	Assaultive	<input type="checkbox"/>	Aggressive	<input type="checkbox"/>	Hyperactive
	<input type="checkbox"/>	Restless	<input type="checkbox"/>	Loss of interests	<input type="checkbox"/>	Withdrawn		
Cognition	Impairment of <input type="checkbox"/> None reported	<input type="checkbox"/>	Orientation	<input type="checkbox"/>	Memory	<input type="checkbox"/>	Attention/ concentration	
		<input type="checkbox"/>	Judgment	<input type="checkbox"/>	Insight	<input type="checkbox"/>	Ability to abstract	
Intelligence estimate	<input type="checkbox"/>	Well below average	<input type="checkbox"/>	Below average	<input type="checkbox"/>	Average	<input type="checkbox"/>	Above average

Social History

Support	<input type="checkbox"/>	Family	<input type="checkbox"/>	Friends	<input type="checkbox"/>	Partner	<input type="checkbox"/>	Membership
	<input type="checkbox"/>	Relatives	<input type="checkbox"/>	Neighbors	<input type="checkbox"/>	Professionals	<input type="checkbox"/>	Coworkers
	<input type="checkbox"/>	Pastoral staff	<input type="checkbox"/>	Mentor				
Interpersonal maturity	<input type="checkbox"/>	Dependent	<input type="checkbox"/>	Impulsive	<input type="checkbox"/>	Irresponsible	<input type="checkbox"/>	Isolated
	<input type="checkbox"/>	Responsible	<input type="checkbox"/>	Self-centered				

Elaboration:

Initial Diagnostic Impression:

RECOMMENDATIONS

Session length	<input type="checkbox"/>	30 minutes	<input type="checkbox"/>	45 minutes	<input type="checkbox"/>	60 minutes	<input type="checkbox"/>	Other (specify)
Frequency	<input type="checkbox"/>	twice weekly	<input type="checkbox"/>	weekly	<input type="checkbox"/>	twice monthly	<input type="checkbox"/>	monthly
Format	<input type="checkbox"/>	Individual	<input type="checkbox"/>	Family	<input type="checkbox"/>	Marital/relational	<input type="checkbox"/>	Group
Classification	<input type="checkbox"/>	Primary	<input type="checkbox"/>	Secondary	<input type="checkbox"/>	Tertiary	<input type="checkbox"/>	Other
Model of therapy	<input type="checkbox"/>	Crisis management	<input type="checkbox"/>	Consultation	<input type="checkbox"/>	Medical evaluation	<input type="checkbox"/>	Prevention
	<input type="checkbox"/>	Psychodynamic	<input type="checkbox"/>	Person-centered	<input type="checkbox"/>	Existential	<input type="checkbox"/>	Adlerian
	<input type="checkbox"/>	Gestalt theory	<input type="checkbox"/>	REBT	<input type="checkbox"/>	Behavioral	<input type="checkbox"/>	Cognitive
	<input type="checkbox"/>	Reality	<input type="checkbox"/>	Family therapy	<input type="checkbox"/>	Other (specify)		
Support groups	<input type="checkbox"/>	12-step program	<input type="checkbox"/>	Alcoholics Anonymous	<input type="checkbox"/>	Narcotics Anonymous	<input type="checkbox"/>	
	<input type="checkbox"/>	Gamblers Anonymous	<input type="checkbox"/>	Overeaters Anonymous	<input type="checkbox"/>	Other (specify)		
Psycho-educational groups	<input type="checkbox"/>	Assertiveness	<input type="checkbox"/>	Anger management	<input type="checkbox"/>	Child management	<input type="checkbox"/>	Communication skills
	<input type="checkbox"/>	Divorce care	<input type="checkbox"/>	Finance management	<input type="checkbox"/>	Grief care	<input type="checkbox"/>	Parenting skills
	<input type="checkbox"/>	Premarital counseling	<input type="checkbox"/>	Stress management	<input type="checkbox"/>	Women's issues	<input type="checkbox"/>	Other (specify)

Referrals for continuing services	Advocacy	Alcohol-drug treatment program	Education on medications & compliance	Educational/vocational services
	Hospitalization	Intellectual evaluation	Legal services	Nursing care
	Occupational/Physical therapy	Outpatient therapy	Offender program	Parochial services
	Personality evaluation	Physical medical care	Psychological evaluation	Psychiatric evaluation
	Psychotropic evaluation	Victim support	Vocational/career counseling	Other (specify)

Elaboration on recommendation(s):

TREATMENT PLAN (Initial)

Complex Treatment Issues:

- | | |
|---|--|
| <input type="checkbox"/> One or more acute admissions in past year
<input type="checkbox"/> Prior treatment attempts without success
<input type="checkbox"/> Suicidal/homicidal behavior
<input type="checkbox"/> Medical co-morbidity
<input type="checkbox"/> Multiple family members in treatment
<input type="checkbox"/> Disorder keeps child out of school
<input type="checkbox"/> Psychiatric disability
<input type="checkbox"/> Prescription medication | <input type="checkbox"/> Multiple providers
<input type="checkbox"/> Agency involvement
<input type="checkbox"/> Community support services
<input type="checkbox"/> Arrests and/or incarcerations
<input type="checkbox"/> Treatment noncompliance
<input type="checkbox"/> Out-of-home placement in past year
<input type="checkbox"/> Disorder related to sexual trauma |
|---|--|

Elaboration:

Behavior(s) to be changed/observable indicators of improvement:

Interventions:

Questionnaires/handouts/assignments given:

Summary:

Clinician's Signature: _____ Date: _____