

INTAKE AND ASSESSMENT INFORMATION

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Interviewing Professional

Treating Professional

Referral source: Self Court DCFS Probation/Parole Friend Other:

Today's Date

1) IDENTIFYING INFORMATION:

Last Name

First

Preferred name if different

Female

Male

2) PRIMARY PRESENTING COMPLAINT, CONCERNS, SYMPTOMS:

Other pertinent issues, complaints, concerns, symptoms, signs, etc.:

3) PSYCHIATRIC, PSYCHOLOGICAL, and/or COUNSELING HISTORY:

None reported or known

4) PSYCHOTROPIC MEDICATIONS: (Name, dosage, date started)

None reported or known

5) MEDICAL/DEVELOPMENTAL HISTORY: (Note relevant, current medical concerns, plus Hx, e.g., serious illness, seizure or thyroid disorder, head injury, birth trauma, exposure to CNS toxins, etc).

6) ALCOHOL and/or OTHER DRUG USE (Substances, age of onset, amount, frequency, consequences, etc.):

No difficulties or concerns noted or reported.

7) SUICIDE, HOMICIDE, VIOLENCE IDEATION (Planning/Intent/Behaviors/History):

N/A Denied Ideation (Passive Active) Plan Intent Commitment to Crisis Response Plan

8) FAMILY HISTORY INCLUDING FAMILY MEDICAL/PSYCHIATRIC HISTORY:

Patient is the ___-born child of ___ children Adopted Family is not intact (if not, explain):

9) PSYCHOLOGICAL and ENVIRONMENTAL PROBLEMS:

- A. Problems with **primary support group**, e.g., divorce, death of spouse or family member, sexual abuse
- B. Problems with **social environment**, e.g., death or loss of friends, living alone, life-cycle transition, discrimination
- C. **Educational problems**, e.g., academic difficulties, discord with teachers
- D. **Occupational problems**, e.g., unemployment, job dissatisfaction, discord with co-workers
- E. **Housing problems**, e.g., homelessness, discord with roommates or landlord
- F. **Economic problems**, e.g., inadequate finances
- G. Problems with **access to health care**, e.g., no health insurance
- H. Problems related to **crime/interaction with legal systems**, e.g., arrest, litigation, crime victim
- I. **Other** psychosocial and environmental problems:

10) STRENGTHS, RESOURCES, APTITUDES, OTHER POSITIVE PROGNOSTIC INDICATORS:

- Person states and/or displays a **high degree of motivation** for insight, change, etc.
- Person has **identifiable skills and/or talents** that may be used in the service of coping
- Person **relates openly** and is **receptive in interaction** with interviewer
- Person is **verbally articulate** and/or is **well able to identify his/her concerns**
- Person appears to display at least **average degree of psychological mindedness** (vs. resistance to considering psychological causes and contributions to presenting problems)
- Person has relatively **few, well defined counseling goals**
- Person has identifiable and consistent sources of **psychological support**, e.g., family friends, belief system
- Person is **not experiencing significant impairment** in academic/occupational functioning

11) STATED GOALS and/or OUTCOMES DESIRED (CLIENT'S VIEW OF CHANGE DESIRED, e.g., Increased self-efficacy, knowledge, Improved self-understanding, improved coping, judgment, impulse control, etc.

A.

B.

C.

12) MENTAL STATUS and BEHAVIORAL OBSERVATIONS:

<p>GENERAL APPEARANCE</p> <input type="checkbox"/> Same as age <input type="checkbox"/> Younger <input type="checkbox"/> Older	<p>HEIGHT</p> <input type="checkbox"/> Average <input type="checkbox"/> Above avg. <input type="checkbox"/> Below avg.	<p>WEIGHT</p> <input type="checkbox"/> Average <input type="checkbox"/> Overweight <input type="checkbox"/> Obese <input type="checkbox"/> Thin	<p>DRESS</p> <input type="checkbox"/> Appropriate <input type="checkbox"/> Disheveled <input type="checkbox"/> Overly neat <input type="checkbox"/> Other	<p>HYGIENE</p> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<p>POSTURE</p> <input type="checkbox"/> Normal <input type="checkbox"/> Rigid/Tense <input type="checkbox"/> Inappropriate <input type="checkbox"/> Other	<p>MANNERISMS</p> <input type="checkbox"/> Normal <input type="checkbox"/> Restless <input type="checkbox"/> Agitated <input type="checkbox"/> Inappropriate <input type="checkbox"/> Slow	<p>RESPONSIVENESS</p> <input type="checkbox"/> Alert <input type="checkbox"/> Vigilant <input type="checkbox"/> Lethargic <input type="checkbox"/> Drowsy <input type="checkbox"/> Other	<p>SPEECH</p> <input type="checkbox"/> Normal <input type="checkbox"/> Talkative <input type="checkbox"/> Garrulous <input type="checkbox"/> Unspontaneous <input type="checkbox"/> Minimal response	<p>AFFECT</p> <input type="checkbox"/> Appropriate <input type="checkbox"/> Blunted <input type="checkbox"/> Restricted <input type="checkbox"/> Labile <input type="checkbox"/> Other
<p>MOOD</p> <input type="checkbox"/> Calm <input type="checkbox"/> Cheerful <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Tearful <input type="checkbox"/> Elated <input type="checkbox"/> Irritable <input type="checkbox"/> Angry <input type="checkbox"/> Fearful <input type="checkbox"/> Other	<p>GOALDIRECTION</p> <input type="checkbox"/> Normal <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<p>JUDGEMENT</p> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Limited	<p>CONCENTRATION</p> <input type="checkbox"/> Normal <input type="checkbox"/> Mildly Impaired <input type="checkbox"/> Moderately <input type="checkbox"/> Impaired <input type="checkbox"/> Severely Impaired	<p>PSYCHOTIC PROCESS</p> <input type="checkbox"/> Delusion <input type="checkbox"/> Obsession <input type="checkbox"/> Paranoia <input type="checkbox"/> Mistaken Ideas <input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/> Magical Thinking
	<p>LOGIC</p> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<p>COHERENCE</p> <input type="checkbox"/> Normal <input type="checkbox"/> Fair <input type="checkbox"/> Incoherent	<p>MEMORY</p> <input type="checkbox"/> Intact <input type="checkbox"/> Short-term deficit <input type="checkbox"/> Long-term deficit	<p>DISTURBANCES IN CONSCIOUSNESS</p> <input type="checkbox"/> Seizures <input type="checkbox"/> Blackouts <input type="checkbox"/> Loss of consciousness

13) MENTAL STATUS and BEHAVIORAL OBSERVATIONS continued:			
DEPRESSION SCREEN <input type="checkbox"/> None <input type="checkbox"/> Appetite change <input type="checkbox"/> Loss of interests <input type="checkbox"/> Guilt <input type="checkbox"/> Motor retardation <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight Change <input type="checkbox"/> Loss of Libido <input type="checkbox"/> Other	SUICIDE SCREEN <input type="checkbox"/> NA <input type="checkbox"/> Previous threat(s) <input type="checkbox"/> Previous attempt(s) <input type="checkbox"/> Hospitalization(s) <input type="checkbox"/> Significant risk factors <input type="checkbox"/> Lack social support <input type="checkbox"/> Severe distress <input type="checkbox"/> Impulsivity <input type="checkbox"/> Increased AOD use <input type="checkbox"/> Plans and preparations <input type="checkbox"/> Other	ANXIETY SCREEN <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe ----- <input type="checkbox"/> Palpitations <input type="checkbox"/> Dizziness <input type="checkbox"/> Faintness <input type="checkbox"/> Sweating <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Panic <input type="checkbox"/> GI Symptoms <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Muscle Ache <input type="checkbox"/> Other	ETOH SCREEN <input type="checkbox"/> NA <input type="checkbox"/> Attempted (or felt should) cut back <input type="checkbox"/> Others annoy/criticize drinking <input type="checkbox"/> Feel guilty about drinking <input type="checkbox"/> Drink to steady nerves or for hangover <input type="checkbox"/> Need more to get usual effect <input type="checkbox"/> History of blackouts or passing out <input type="checkbox"/> History of getting sick after drinking <input type="checkbox"/> History of binge drinking Av. Freq. of drinking: ----- Av. # drinks: ----- Duration: -----
INTELLIGENCE <input type="checkbox"/> Above average <input type="checkbox"/> Average <input type="checkbox"/> Below average	INSIGHT <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Limited	MOOD and AFFECT <input type="checkbox"/> Congruent <input type="checkbox"/> Incongruent	ORIENTATION <input type="checkbox"/> X 4 (if not, note orientation below) <input type="checkbox"/> _____
14) TREATMENT FACTORS (Rate the following on a 1-10 scale):			
Client's propensity for insight regarding problems (<i>Highly unaware 1 to highly insightful 10</i>)			
Acceptance of responsibility for presenting problems (<i>Denies, externalizes 1 to accepts responsibility 10</i>)			
Client's readiness/motivation for change (<i>Very resistant to change 1 to highly motivated to change 10</i>)			
Ability/readiness to form therapeutic alliance at present (<i>Very resistant/unable 1 to highly willing and able 10</i>)			
Prognosis for change (<i>Very poor 1 to excellent 10</i>)			
15) DSM-IV DIAGNOSTIC IMPRESSIONS: (Date all Dx changes made after initial assessment)			
Axis I: <i>Clinical Disorders , Other Conditions as Focus of Clinical Attention</i>			
Axis II: <i>Personality Disorders, Mental Retardation, Defense Mechanisms</i>			
Axis III: <i>General Medical Conditions</i> <input type="checkbox"/> None identified			
Axis IV: <i>Psychosocial and Environmental Problems (See section 9 above)</i> <input type="checkbox"/> None identified			
Axis V: <i>General Assessment of Functioning (GAF) level, 0 -100</i>		Current:	Highest Past Year:
16) RECOMMENDATIONS: (Check all that apply)			
<input type="checkbox"/> Further assessment or evaluation: <input type="checkbox"/> With interviewer <input type="checkbox"/> Psychological testing recommended <input type="checkbox"/> LD/ADHD assessment recommended <input type="checkbox"/> Other:			
<input type="checkbox"/> Individual counseling or psychotherapy <input type="checkbox"/> With interviewer <input type="checkbox"/> With:			
<input type="checkbox"/> Group counseling (List group(s))			
<input type="checkbox"/> Referral for psychiatric evaluation <input type="checkbox"/> Urgent			
<input type="checkbox"/> Referral for medical evaluation <input type="checkbox"/> Urgent			
<input type="checkbox"/> Referral for AOD assessment <input type="checkbox"/> Urgent			
<input type="checkbox"/> No further services are recommended or interviewee does not desire further assistance			
<input type="checkbox"/> Referral to other resources or providers:			
<input type="checkbox"/> Other recommendations:			
Signature/License/Certification:			DATE:
Supervisor's Signature (Interns only):			DATE:

TREATMENT PLAN (or Tx Plan Update)

Client name:		Date:		Review Date:	
Indicate what treatment client will receive. Update periodically throughout client's course of therapy.					
1) Treatment Goals (and/or changes desired by client):					
Decrease:		Increase:			
<input type="checkbox"/> General affective distress	<input type="checkbox"/> Self-harming behaviors	<input type="checkbox"/> Self-esteem	<input type="checkbox"/> Support system		
<input type="checkbox"/> Somatic symptoms	<input type="checkbox"/> Negative relationship interactions	<input type="checkbox"/> Goal-directed thinking	<input type="checkbox"/> Social skills		
<input type="checkbox"/> Self-defeating thoughts	<input type="checkbox"/> Other:	<input type="checkbox"/> Autonomy/individuation	<input type="checkbox"/> Problem-solving skills		
<input type="checkbox"/> Substance abuse		<input type="checkbox"/> Impulse control	<input type="checkbox"/> Academic/school functioning		
<input type="checkbox"/> Reliance on medication		<input type="checkbox"/> Self-awareness	<input type="checkbox"/> Pro-social behaviors		
Other:					
2) Treatment Focus and Objectives (e.g., tasks, modalities, and strategies to be utilized in Tx):					
Specific interventions, medical:		Specific interventions, non-medical:			
<input type="checkbox"/> Drug screening	<input type="checkbox"/> Crisis management	<input type="checkbox"/> Behavioral contracting	<input type="checkbox"/> Cognitive restructuring		
<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Self-monitoring	<input type="checkbox"/> Augment coping skills	<input type="checkbox"/> Relaxation/Stress management		
<input type="checkbox"/> ADD/ADHD meds	<input type="checkbox"/> Bibliotherapy	<input type="checkbox"/> Support	<input type="checkbox"/> Anger management training		
<input type="checkbox"/> Medication monitoring	<input type="checkbox"/> Conflict management	<input type="checkbox"/> Explore family dynamics	<input type="checkbox"/> Improve social/communication skills		
<input type="checkbox"/> Anxiolytics	<input type="checkbox"/> Build alliance/rapport	<input type="checkbox"/> Explore etiology of anxiety	<input type="checkbox"/> Address transference feelings		
<input type="checkbox"/> Medical tests	<input type="checkbox"/> Sexual behavior Tx	<input type="checkbox"/> Freeze-Framer	<input type="checkbox"/>		
Other:					
3) Behavior Change and Other Indicators of Client Improvement (e.g., improved self efficacy, judgment, insight, impulse control, etc.):					
A.					
B.					
C.					
4) Estimated duration of therapy: <input type="checkbox"/> 1-3 sessions <input type="checkbox"/> 4-8 sessions <input type="checkbox"/> 8-15 sessions <input type="checkbox"/> >15 sessions					
5) Additional comments regarding treatment plan, treatment modalities, case disposition, university administrative issues, etc. Include rationale for extended treatment if it is anticipated that psychotherapy will exceed 8 sessions per term.					
Signature/License/Certification:				Date:	
Supervisor's Signature (Interns only):				Date:	

TERMINATION SUMMARY

Client name:

To be completed at conclusion of treatment and/or two weeks after last scheduled contact.

1) Presenting Problem or Complaint:

2) Summary of Treatment:

3) Treatment Progress: excellent good fair poor NA

4) Prognosis: good fair guarded poor unknown

Current GAF:

5) Final Diagnostic Impression(s):

Axis I

Axis II

Axis III

Axis IV

Axis V

6) Date of last contact:

7) Number of Sessions:

___ Walk-in ___ Intake ___ Individual ___ AOD Assess. ___ Group ___ Psychiatrist ___ No-show ___ Other:

8) Type of termination (Check all that apply):

- Mutual agreement between patient and therapist; treatment goals met
- Mutual agreement between patient and therapist; treatment goals NOT met
- Total number of available individual sessions reached
- Medical/Psychological withdrawal from school
- Graduation/Ineligibility
- End of academic year
- Unilateral termination due to failure to return to Center/failure to keep follow-up appointments
- Other:

9) Referrals on termination (Check all that apply):

- None Private resources Other Center or Campus services:
- Community resources:
- Other:

Signature/License/Certification:

Date:

Supervisor's Signature (Interns only):

Date: