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Program Faculty

Marsha Wiggins, Ph.D.  
Professor Clinical

Pat Larsen, Psy.D.  
Director

Andrew A. Helwig, Ph.D.  
Professor

Farah Ibrahim, Ph.D.  
Professor

Diane Estrada, Ph.D.  
Assistant Professor

Phil Rutter, Ph.D.  
Assistant Professor

Carlos Hipolito-Delgado, Ph.D.  
Assistant Professor

Clinical Staff

Christine Casey Perry, MA, LPC  

Cindy Wang-Toxby, Psy.D

Ruth Possehl, MA, LPC  

Lorrie Schroffel, MSW

Honorarium Faculty

Rick Ginsberg, Ph.D.  

Betsy Coppock, MA, LPC

John Kirk, Ph.D.

Academic Advisor

Marlinda Hines, MA

Administrative Staff

LeThi Cussen
PRACTICUM OBJECTIVES AND REQUIREMENTS

The Practicum experience is considered one of the most important professional activities in which students engage during their degree program. Practicum students are given opportunities to synthesize and apply knowledge gained in their course of study and other academic pursuits. Through the sharing of experiences in both group and individual supervision, students may refine previously learned skills and acquire new skills.

Practicum Objectives

The Practicum is designed to facilitate refinement of counseling and interview skills and the development of new skills. Through closely supervised one-on-one group supervision experiences, the student can expand his or her repertoire of counseling techniques and interpersonal relationship skills.

Through the use of the facilities at the UCD Student & Community Counseling Center, students will be given an opportunity to experience direct and specific feedback from their supervisors through the use of video recording, as well as direct observation through one-way glass.

In the Practicum, students will be expected to demonstrate a commitment to implementing and expanding the following skills:

• Establishing and maintaining a helpful and supportive counseling relationship.
• Development and application of appropriate counseling techniques.
• Maintaining client records, scheduling client appointments, learning about and using community resources when appropriate.
• Working effectively with supervisors and colleagues, including appropriate analysis and presentation of counseling sessions and case studies.
• Continued development of professional behavior.
• Enthusiasm for and commitment to the counseling profession.
• A continued willingness to learn.
• Continued development of personal traits that are conducive to effective counseling, learning and professional development.
• Diagnosis and treatment planning.

Practicum Hours

Prior to enrolling in the Practicum, students will be expected to have completed all of their coursework with no incompletes, excepting the REM courses. If the Practicum class is full, students who have all of their coursework completed will be given priority.

Students signed up for 6 credit hours of Practicum must be prepared to commit a minimum of 150 hours to the Practicum. Distribution of these hours is as follows:

1) Direct contact (one-on-one, and/or couples, families) 30 hrs.
   16 of the 10 direct hours must be with couples and/or families for CFT Students
2) Outside Group Experience 10 hrs.
3) Individual supervision (1 hour per week for each week student is seeing clients) 15 hrs.
4) Practicum Class (1 ½ hours per week for 15 weeks) 22 hrs.
5) Peer Observation 15 hrs.
6) Outreach 10 hrs.
7) Additional hours-activities approved by Supervisor 48 hrs.

MINIMUM REQUIRED HOURS 150 hrs.
If you are in the Couple and Family track, the majority of the direct service hours must be with couples and/or families. A couple means two persons, not necessarily married, who attend sessions and are counseled together by the same counselor. A family may or may not include a couple, but must include a parent or guardian and a child who attends sessions and are counseled together by the same counselor.

Practicum students are required to facilitate an on-or-off campus group experience. The group that you would like to lead must be pre-approved by your individual supervisor. The group must be co-facilitated by an experienced, preferably licensed clinician.

Students should be prepared to spend AT LEAST 15-20 hours per week over a 15 week period in Practicum activities (summer Practicum students should be prepared to spend at least 20-25 hours per week over a 10 week period). Due to the varied availability of clients, students should be prepared to spend more hours in one-on-one sessions as the semester progresses.

Normally, students are expected to meet with their clients in the Center facilities at the University. Should special circumstances necessitate meeting at another location, the student must have the prior permission of their Practicum Supervisor and the Practicum Director. In addition, arrangements to see the client for at least three meetings during the semester at the Center must be made in order to obtain supervision by direct observation and/or video recording of a counseling session. Students are required to see a minimum of two clients through the UCD Student and Community Counseling Center during the regular semester.

Evaluation and Grading

In addition to informal evaluations during individual supervisory sessions, Practicum students will be formally evaluated by their supervisors on a variety of skills and activities at midterm and again at the end of the semester. Maintenance of client contact information including contact hour logs and client records will be included in the evaluation as well as attendance at both individual and group supervisory sessions.

Additionally, clients will be given an opportunity to evaluate their counselor as part of client satisfaction surveys, as well as make comments on the services they have received through the Center. Client’s comments will be shared with the Practicum student's supervisor if mentioned by name.

Letter grades will be given based on the following considerations:

- Attendance at class meetings.
- Professional/ethical behavior.
- Completion of required number of clock hours.
- Evaluation of skills and performance on Practicum Student Midterm and Final evaluations.
- Timely completion of all paperwork.
- Accurate note taking and record keeping.
- Arranging and attending individual supervision on a weekly basis.
- Following through with clinic polices & requirements.
- Openness to, and incorporation of Supervisor feedback.

The final grade reflects level of performance at the end of practicum. The grade is not cumulative.

A letter grade of “A” indicates that in addition to completing all course requirements in a timely and professional manner, the student demonstrates excellent counseling skills, high standards of professional and personal behavior, a continued willingness to learn, and a commitment to the counseling profession.
A letter grade of “B” indicates that in addition to completing all course requirements in a timely and professional manner, the student demonstrates strong counseling skills, above average standards of professional and personal behavior, a continued willingness to learn, and a commitment to the counseling profession.

A letter grade of “C” indicates that the student did not complete all course requirements in a timely and professional manner, needs to improve counseling skills, may need to examine personal and/or professional standards, appears to be unwilling to learn or lacking in commitment to the counselor profession. Further, the student will be required to re-take Practicum after s/he has fulfilled the additional stipulations required of him/her by the faculty, and may lead to a re-evaluation of the student’s participation in the counseling program by his or her faculty advisor, Practicum supervisor, the Practicum Director, and CPCE faculty. Students may only repeat their Practicum once.

A letter grade of “F” is given in cases of unethical behavior or grossly lacking counseling skills. In this situation, re-evaluation of the student’s participation in the program will be done by the Supervisors, Practicum Director, and the Division Director, developing a remediation plan for the student or possibly resulting in dismissal from the program.

In cases where the student has failed to meet the required number of clock hours, a grade of “IW” (Incomplete) will be given. Failure to complete the requirements within one semester will result in re-evaluation of the student’s continued participation in the counseling program.

Accommodations

If a practicum student wants/needs accommodations, they must work with the office of disabilities to specify the accommodations they are requesting. If they don’t ask for accommodations, it will be assumed that the student is able to perform all the functions required of practicum as outlined in the competency document.

Repeating Practicum

The supervisory team consists of the Clinic Director, clinic staff, and supervisors. The team evaluates students’ progress bi-monthly and conducts formal evaluations at midterm and at the end of the semester. The supervisory team may identify students who are not meeting Practicum objectives at the midterm evaluation. In these cases, a formal remediation plan will be designed by individual supervisor and the practicum student. Both will sign the document and track progress. These students may be required to continue in Practicum for a second semester unless they have proven themselves to be proficient by the final evaluation at the end of the semester. Students who are required to repeat Practicum must register for CPCE 5910 for 3 credit hours and must participate fully in the course requirements for the duration of the subsequent semester. Students repeating Practicum may not register for Internship (CPCE 5930) until they have completed Practicum successfully.

Completing Couple and Family Hours

If a student is in the Couple and Family Track and cannot complete the required 16 hours of direct service with couples and families due to a lack of clients, the student may be allowed to move on to Internship if the following requirements are met:

- The student’s number of direct service hours totals 30 or more.
- The student has at least 12 hours of direct service with couples or families.
- The student has demonstrated a skill level that the supervisory team agrees is sufficient for Internship.
• The student is performing at an acceptable skill level, has made a concerted effort to complete the required hours, and was only hindered by a lack of couple or family clients on their caseload.

If the student is given permission to move on to Internship, the procedure will be as follows:

• The student will receive an IW in Practicum, which will be changed to the appropriate grade following the completion of the required direct service hours.
• The student will complete the required hours at their Internship site and will submit a final Practicum Log once the required hours have been completed.
• Hours counted toward the completion of Practicum may not be counted as Internship hours.

Mission Statements and Goals

Service to CU Denver Students, Faculty, and Staff - We, at the UCD Student and Community Counseling Center, (hereafter referred to as "the Center"), believe that students' successes are dependent on their emergence as whole human beings, and dedicate ourselves to delivering the best possible help and guidance. We act in partnership with the Mission of this University to enhance students' optimal educational experiences. We help students to establish themselves as contributing individuals responding to "the challenges of an urban environment". The staff of the Center serve as experts and consultants to CU Denver faculty, staff and parents regarding the mental health needs of students. All students receive a service benefit of an intake session and ten (10) additional counseling sessions at no cost. Students may continue beyond the 11th session on a fee for service basis based on income. Students have the option of being seen by one of our licensed professional staff (in this case, sessions are limited) or one of our student counselors on an unlimited basis. Students may wish to transfer to a student counselor when they have reached their session limit with a staff counselor. These benefits are renewed on a yearly basis.

The Center staff is available to help with campus mental health emergencies, and to provide consultation for troubled students and staff. Staff is also available upon request for classroom and departmental in-services on a variety of topics related to college students and mental health. Further, the staff will provide a one-time mental health consultation for any UCD faculty or staff upon request.

Service to the Denver Area Community - The Center provides low cost or no cost mental health and counseling services to students and families in a partnership with the Denver Public Schools. We also provide low cost services to any community member who qualifies for our services. Many of our clients would otherwise go without the benefit of mental health services. Several private and public community agencies refer clients to our Center.

Service to CPCE student training - The Center is part of the professional training program in the Division of Counseling Psychology and Counselor Education at UCD. The Center serves as the “in house” clinical training site and research center. As a clinical training site, the Center provides opportunities for Master’s level Practicum and Internship students to provide quality services through different modes of treatment such as individual, couple, family and group counseling under the supervision of qualified clinicians and faculty members. As a research center, this site provides opportunities for research that can improve our understanding of human coping mechanisms and how clinicians can be trained to better serve the needs of a diverse community population.

Philosophy

The staff at the Center believes in a health-oriented model and values an integration of diverse theoretical modalities. Our staff also responds to the developmental challenges individuals and their families may be facing.

Quality of Services
The Center is committed to offering high quality counseling services to clients on a restricted basis. As a training facility, the Center has a limited number of students who are allowed to deliver services to clients. These students are carefully selected and supervised by the clinical faculty. The Center operates on a walk-in, referral, and appointment basis. To ensure that clients benefit from the services, all clients are initially screened to determine their counseling needs. The Center maintains a continuous quality assurance program and client satisfaction program.

**Limitations of Services**

The Center is not able to provide 24-hour care; therefore, the Center provides appropriate referrals to individuals (e.g., in-patient substance abuse, acutely suicidal, homicidal, or psychotic) in need of more intensive treatment and continuity of care. In these cases, supervisors will collaborate with the appropriate agencies in order to assure client safety. Some services may be requested that are beyond the scope of our competencies such as forensic assessments or child custody evaluations. In these cases referrals will be made to other agencies.

**Confidentiality and Client Records**

The Center will collect and maintain records in written and taped formats in order to provide the highest quality of supervision and counseling services to clients who are seen at the Center. Information collected includes: assessment data, taped recording of sessions, progress notes, and information supplied by other agencies involved with the client. The policies regarding public records will be adopted to preserve the protection of the client’s right to privacy and the fulfillment of the professional responsibilities of confidentiality. All information obtained is confidential and can only be released with the client’s written consent. The exceptions to the right to confidentiality are when disclosure of records is mandated by federal and state laws such as court order, risk of harm to self or others, and child or elder abuse.

**Public Records**

In keeping with ethical standards of mental health professionals (American Counseling Association, American Psychological Association, and American Association for Marriage and Family Therapy), all counseling services will be confidential.

**Disclosure of Confidential Information**

**Client Access to Records** - Access to records and copies of records will be provided when requested by competent clients, their legal representatives or parents/legal guardians of minors, unless the records contain information that may be misleading and detrimental to the client. When records contain such information, the counselor or agency may provide a report of examination and treatment in lieu of copies of records. Upon a client’s written request, complete copies of the client’s records will be provided directly to a subsequent treating mental health professional. In situations involving multiple clients, access to records is limited to those parts of records that do not include confidential information related to another client.

**Disclosure of Confidential Information to Third Parties** - A client may request that information regarding assessment data, test interpretations, or other information gathered in the course of counseling be released to other appropriate mental health professionals. These requests must be in written form through the completion of an Information Release Form, which can be obtained from the counselor-in-training or the clinical supervisor. Telephone requests will not be honored, but the Information Release Form can be mailed to the caller. The form includes: a) the individual or agency to whom the information is to be released; b) the kind of information to be released; c) the reason for requesting the release; d) the client’s date of birth; e) the client’s signature; and f) the signature of a witness.

**Disclosure of Confidential Information Prior to Consent** - (i.e., disclosure due to health and safety emergencies) Information may be released from client records to appropriate persons in connection with an emergency if the
knowledge of such information is deemed necessary to protect the welfare of a client or other persons. A counselor has a legal responsibility to follow procedures for dealing with potentially violent clients when he or she becomes aware of potential violent behavior on the part of the client. Counselors have an ethical responsibility to follow procedures for dealing with potentially suicidal behavior on the part of the client. Counselors have a legal responsibility to report to the local police authority or to the local child protection services any instance of suspected or reported child abuse.

Disclosure Pursuant to Requirements of Law - Confidential information will be released if so ordered by a court of competent jurisdiction or otherwise as the law requires. In such a case, an attempt will be made to notify the client prior to the compliance.

Disclosure for Research Purposes - Clients participating in research studies conducted by the UCD Student and Community Counseling Center will be informed of the safeguards against disclosure in the research design. Research studies of this nature demand prior client knowledge and consent. All research studies will have obtained permission from the Human Subjects Board prior to the collection of data.

Research Projects Involving Clinic Records and Clients - Due to the need for confidentiality of client records and the requirements for the protection of human subjects, it is necessary for all proposed research projects to be reviewed and approved by the Human Research Committee, the clinical faculty, and the Division Director prior to implementation.

Fees

UCD students are eligible for up to 10 free sessions per academic year. After the 10 free sessions, they may continue services on a sliding scale payment basis. For clients who are members of the greater Denver Metro community, there will be a sliding fee scale which will be used to determine payment for counseling services based on family size and annual household income.

Parental Consent for the Counseling of Minors

All minors (under 16) will be required to have parental or guardian consent for services. In cases where minors live with a legal guardian, a court document must be presented giving the guardian the right to provide permission for mental health services. For clients 16-18yrs old, the center strongly recommends written parental consent.

1. In order to provide counseling for a child under the age of 18, the Center requires signed parental consent from the child’s legal guardian/guardians. When treating an adolescent, an agreement with parents can be discussed at intake about what information will and will not be shared with parents. Parents and therapist should sign the agreement describing the parameters of limited confidentiality of the minor child. In cases of emergency, the Center will inform the parent or legal guardian regardless of any previously signed agreements.

2. In cases of divorce, a parent who has legal custody of the child may give consent. “Legal Custody” is a designation as a result of a court action.

3. In case of divorce, if both parents have “joint custody”, then it is recommended that both parents sign the consent forms. Where there is joint custody and a disputes arises about the necessity of our the type of treatment provided to the minor child or children, either parent shall be allowed to obtain necessary medical treatment for the minor child without violating the joint custody order (C.R.S. 14-10-123.5)

4. If only one joint custody parent signs the consent, a letter should be sent to the other parent informing him/her that counseling services are being provided.
5. If a parent has “sole custody” of a minor child that parent with the authority to make all major decisions concerning the child’s health, education and general welfare. His or her consent is all that is required by the Center to provided counseling for the minor child. In emergency situations, the non-custodial parent may consent to necessary medical treatment for a minor child. Even in those situations where a non-custodial parent does not have the right to control the patient’s care, he or she can request the patient’s medical records. (C.R.S. 14-10123.5)

6. A parent of a minor, by a properly executed power of attorney, may delegate another person, for a period not exceeding nine months, any of his or her powers regarding care, custody and decision-making responsibility, including the power to consent to medical care and treatment (C.R.S. 15-14-104)

7. Health care providers should assume that no other person possesses the authority to authorize a minor’s medical record. The primary exception to this rule is where a court has awarded legal custody to another family member or institution. Under Colorado law a court may award legal custody of a minor to another party when it is in the minor’s best interest. Any court appointed guardian is awarded the power to authorize medical care and treatment for the minor.

8. Minors of at least **fifteen years of age** can consent to treatment if:
   a. he or she is living separate and apart from his or her parents or legal guardians and managing his or her own financial affairs
   b. is legally married
   c. is a parent and requests medical records of his or her child
   d. is requesting birth control or termination of pregnancy information
   e. is requesting counseling about venereal disease
   f. any minor may also request treatment for drug dependency through any approved treatment facility

**Tape Recording and Observation**

Informed Consent for Recording and Observing Sessions - Clients will be first informed of The Center's policy on recording and observation of counseling sessions when they call to obtain information or to make an appointment at The Center. Additionally, they will receive written information about taping and observation of sessions. This information packet will inform potential clients of The Center's requirement that all clinic sessions be observed.

Consent for Recording - Clients are to be informed that their sessions' audio or video tape will be used for training and supervision purposes and that the information is kept confidential as is all client information (as is set forth on the section on confidentiality). A signed consent form indicating their agreement to the taping and observation of session requirements must be completed before the first session. If a community client refuses to be taped or observed, the counselor-in-training will provide referrals to other counseling agencies.

**Professional Liability Insurance**

All persons delivering services in The Center (e.g., both faculty and students) are required to have a professional liability insurance policy currently in effect. The limits of liability will be $1 million, $3 million.

**Supervisor Responsibilities with Supervisees Counseling Clients**

The faculty supervisor will be responsible for the quality of care provided clients seen at The Center by supervisees under his/her direction. The supervisor will work with the supervisee working with the client. However, in some cases in which the supervisee is judged not yet adequately trained to work with a particular client situation, the supervisor may take over the responsibility for the case. In such situations, the supervisor and the supervisee will consult together about the case before such decision is finalized.
PROCEDURES

Information Giving and Intake Procedures

1. Phone calls or requests for information about The Center will be handled by counseling center's administrative assistants who will be responsible for providing information about the counseling center to interested callers.

2. Interview of prospective clients will be handled by counselors in training under the supervision of clinical supervisors. During the interview, appropriate preliminary intake information will be gathered in order to assess eligibility and the possibility of a client being seen at The Center. Intake information will be given to the Clinic Director who will assess whether or not The Center is appropriate for the client. If the client is accepted for services, a counselor will call the client and arrange an appointment time for services. The first three sessions provided to clients are considered continued assessment and treatment plan development sessions.

Appointments

Appointments are to be scheduled by individual counselors. Counselors are responsible for updating the schedule book at the Front Desk of The Center to reflect their schedule appointments and room number. Client appointments are to be scheduled only when a supervising faculty member is on call in the department.

Client Record Keeping Procedures

In order to comply with The Center's ethical, professional, and legal responsibility to maintain records on behalf of past, present, and potential clients in a confidential manner, a professional file will be developed on each client containing: a) initial assessment interview notes, b) intake summary and case treatment plan, c) case progress notes, d) termination summary, e) client consent documents, e) assessment reports, and f) any other documents appropriate to the treatment of the client. This professional client file will be maintained in a secured room for 5 years beyond termination of client services.

A client who asks to see his/her/their record may receive a (verbal) summary from any counselor involved or from the Clinic Director/supervisor if the counselor is no longer on the clinic staff.

In accordance with applicable federal and state laws, the requirement for written release is waived in a health or safety emergency for the duration of the emergency. The following must be considered in determining whether disclosure without prior written consent may take place:

1. The seriousness of the threat to the health and safety of the student or other individuals
2. The need for the information to meet the emergency
3. Whether the parties to whom the information is being disclosed are in a position to deal with the emergency
4. The extent to which time is of the essence in dealing with the emergency

The counselor acknowledges the responsibility in making decisions regarding disclosure of information and to whom such information may be disclosed. Consultation with a Clinical Supervisor or the Clinic Director should be sought. In some cases, it may be appropriate for the information to be communicated through the Clinical Supervisor or Clinic Director if direct contact between the counselor and the recipient would be inappropriate.

Procedural Guidelines for Dealing with Potentially Violent Clients

A counselor in the UCD Student and Community Counseling Center has a legal responsibility to follow certain procedures when he/she becomes aware of potentially violent behavior on the part of the client.
A. Evidence of Potentially Violent Behavior - The following criteria is sufficient cause for notification to the intended (identifiable) victim and for the invocation of these procedures:

1. When there is a clear and immediate probability of physical harm to the client.
2. When there is a clear and immediate probability of danger to other individuals.
3. When there is a clear and immediate probability of danger to society.

B. Procedures to Follow

1. Evaluation and Documentation -- As part of the process of identifying the intended violent action (threatened violence towards a specific victim), the counselor should immediately:
   a. Notify their clinical supervisor or other clinical faculty designated in the Counseling Center (This conversation should be noted in writing and signed by both parties).
   b. Assess the potential for violence by referring to the checklist in Appendix G.
2. Based upon consultation, a mutual decision will be made with respect to the level of danger and whether to begin crisis management procedures.
   a. It is recommended that the supervising faculty consult at least one other clinical faculty to assess danger and determine a course of action.
   b. In cases where there appears to be no real danger, in the opinion of at least two clinical faculty members, a decision may be made to proceed no further in the evaluation at that time.
   c. In cases where there appears to be reasonable concern for danger, a decision may be made to undertake further evaluation. In those instances, the following steps 3 through 8 may be initiated so long as there remains reasonable concern.
3. The clinical faculty will meet to determine a treatment plan, intervention strategies, or to consider options such as further psychological assessment, referral to an outside professional, or other appropriate medical/psychiatric collaboration.
4. Continual contact with the Clinic Director and other supervising faculty.
5. In cases involving UCD students, appropriate University officials will be notified.

Notification of Client, Police and Intended Victim (see relevant policies for further details)

1. Notify the client at the time of disclosure, as set out in the section above, that you have a duty to warn the intended victim and the local police.
2. Notify the police, or other appropriate agencies. This should include the police in the community of the intended victim. Be specific about the threat and the nature of the assistance required.
3. Notify the intended victim. Be specific regarding the nature of the threat and other steps in process or steps intended (i.e., phone call, certified mail)

Data Collection and Evaluation of Services

Data pertaining to the characteristics and quality of the services offered, the nature of the client populations served, and types of problems encountered will be routinely collected to assist the Counseling Center in its research on particular client difficulties and future planning. Types of data collected may include the following:

- client information containing demographic information about the client/client system and the nature of his or her concerns
- counseling goal identification
- evaluation of services
Clients requesting more than one simultaneous counseling modality

Clients at the Center may request more than one treatment modality. For example: a family who is seeking family counseling may also request individual child treatment. Or one or both partners in couples counseling may request individual adult counseling in addition to their couples work.

The general Center policy is that a client may be in only one treatment modality at a time. This policy does not apply to situations where, for instance, a child and a mother are both receiving individual therapy from different therapists and are not also in conjoint therapy.

Exceptions that may be granted to this general policy based on the individual case and therapeutic needs of the clients. Therefore, if a student/counselor would like the Center to consider a treatment plan that involves more than one simultaneous counseling modality for a client, the following procedures will be followed:

1. Discuss the rationale for an exception with your individual supervisor
2. Complete the request form outlining the request and the rationale signed by both the student/counselor and the supervisor
3. Submit the written request to the clinic Director for review. The clinic Director will have the final approval authorization.

If the request is approved:

1. Clients will be notified that all treatment will be reviewed every semester and may or may not receive approval for the next semester.
2. Clients are aware that they are financially responsible for all treatment provided.

Sick Time

The Staff of the UCD Student and Community Counseling Center and Practicum Training Clinic recognize that we as professionals are committed to our work life as well as to our personal relationships including the care and welfare of our children. At times, we recognize that parenting responsibilities will trump our professional commitments. When children are ill, in need of home care, and other childcare arrangements are not viable, we encourage and support both staff and trainees staying home even if that means rescheduling clients. We do not support bringing sick children and/or children who are in need of childcare to the Center. For several reasons, sick children and/or young children need to be cared for at home, not at work. If on occasion, staff or trainees need to stop by the Center for a few minutes, children may accompany them.

PRACTICUM SUPERVISION

Supervision is one of the most important learning aspects of your practicum experience. Here are some tips to maximize you supervision experience.

Supervision Hours

1) Individual Supervision 1 hour/week.
2) Live Supervision every session
3) Practicum Class/Supervision 1.5hrs/week
4) Off Site Group Supervision 1hr/group meeting.

Individual Supervision
• Come to individual supervision prepared
• know and prioritize your needs
• keep a supervision notebook
• give your supervisor an up to date list of your clients
• identify a session or part of a session to view with your supervisor
• identify any personal concerns or individual reactions to clients that may get in the way of your effectives and bring them up with your supervisor
• bring up any concerns in the supervisory relationship or with your practicum experience in general
• check in with your supervisor about your progress/goals
• identify any possible ethical and/or safety concerns with your supervisor

**Live Supervision**

• Fill out yellow supervision sheet with specific goals for the session
• Alert the live supervisor to any planned session strategy before the session begins
• Take a break earlier rather than later in the session
• When there are safety issues or other concerns, take a break and check in
• Check in at the end of the session to get feedback from the supervisor
• Be open to different perspectives.
• Be willing to move from your comfort zone and try new strategies as suggested by your live supervisor.

**Practicum Class/Supervision**

• Do your readings
• Keep a practicum experience journal
• Participate and support your peers
• Ask for time if you need it. Peer supervision can be very helpful!!!
SECTION 1: PROFESSIONAL RESPONSIBILITIES

1) Individual Supervision
2) Group Supervision
3) Record Management
4) Professional Behavior
5) Ethical Behavior

SECTION 2: CLINICAL SKILLS AND RESPONSIBILITIES

6) Initial Intakes
7) Therapeutic Structure, Treatment Planning, and Goal Setting
8) Counseling Theories and Case Conceptualization
9) Therapeutic Alliance
10) Core Counseling Skills and Techniques
11) Multicultural and Diversity Integration

SECTION 3: COUNSELOR IDENTITY DEVELOPMENT

12) Evaluation of Self as Professional Counselor
13) Self-Knowledge

SECTION 4: SPECIALIZED COUNSELING SKILLS

14) Couple and Family Skills and Techniques
15) Play Therapy
SECTION 1: PROFESSIONAL RESPONSIBILITIES

1) Individual Supervision
   □ Is punctual.
   □ Is prepared for each meeting (as directed by individual supervisor).
   □ Identifies supervision needs and goals to achieve.
   □ Initiates interactive dialogue with supervisor.
   □ Informs supervisor of potential crises, safety concerns, or unfamiliar situations.
   □ Maintains openness to new or different clinical procedures, techniques, and concepts.
   □ Is willing to receive and use feedback.
   Comments:

2) Group Supervision (based on feedback from group supervisor)
   □ Gives specific and informative feedback to group members.
   □ Receives and integrates feedback in a non-defensive manner.
   □ Values and utilizes group supervision as a venue for meaningful self-disclosure and self-reflection.
   □ Demonstrates effective skills in case presentation.
   □ Formulates diagnostic impressions using the DSM-IV multiaxial classification system.
   □ Completes all course assignments and requirements.
   Comments:

3) Record Management
   □ Accurately completes all required paperwork in neat, readable, concise manner.
   □ Completes paperwork in a timely manner without reminders.
   □ Expresses information clearly and effectively, including intakes, progress notes, treatment plans, and termination summaries.
   □ Keeps records confidential.
   Comments:

4) Professional Behavior
   □ Presents professional appearance.
   □ Effectively communicates needs and concerns.
☐ Is respectful of others’ time.
☐ Exhibits respectful and courteous behavior.
☐ Understands and maintains appropriate interactions and boundaries with clients and colleagues.
☐ Respectful of others’ values and preferences.
☐ Furthers professional development through workshops, seminars, readings, etc.
☐ Demonstrates a commitment and adherence to the operation and mission of the Center.

Comments:

5) Ethical Behavior Rating 1-5
☐ Demonstrates an awareness and understanding of ethical practice as outlined by all relevant ethical codes (e.g., ACA, AAMFT) and Center policies and procedures.
☐ Demonstrates awareness of and compliance with all state and federal laws related to mental health practice.
☐ Understands the importance of ethical behavior.
☐ Demonstrates critical thinking in ethical decision-making.
☐ Readily seeks consultation for unique or unusual situations.
☐ Effectively practices ethical decision-making and intervention (e.g., child abuse reporting, domestic violence, suicidal assessment and intervention, understanding dual relationships).

Comments:

SECTION 2: CLINICAL SKILLS AND RESPONSIBILITIES

6) Initial Intakes Rating 1-5
☐ Orients client to center policies and procedures.
☐ Demonstrates ability to easily develop rapport with new clients, communicating authentic caring versus being a “technician.”
☐ Develops a connection for the client with the Center rather than to the intake therapist as an individual.
☐ Uses clinical judgment and clarifying questions to thoroughly cover all areas of client history and functioning that are associated with the presenting problem.
Thoroughly assesses risk factors such as homicide, suicide, domestic violence, and ability to manage tasks of daily living.

Follows clinic intake protocols and completes the full intake assessment within a 50-minute session.

Comments:

7) Therapeutic Structure, Treatment Planning, and Goal Setting  
   Rating 1-5
   - Assists client in identifying salient treatment issues and themes.
   - Formulates collaborative treatment plan with client, including long-term goals, short-term goals and objectives as well as interventions.
   - Assess client progress towards treatment goals.
   - Continuously evaluates and resets therapy goals.
   - Directs the focus of session towards discussion and interventions related to treatment goals and objectives.
   - Monitors counseling expectations and agreements (e.g., session time, fee for service, scheduling appointments).
   - Recognizes the need for referral and collaboration with outside resources.

Comments:

8) Counseling Theories and Case Conceptualization  
   Rating 1-5
   - Applies counseling theories and techniques appropriate to each client and clinical situation.
   - Demonstrates an ability to use a pluralistic and integrated approach to clinical work.
   - Assesses client readiness for change.
   - Uses case conceptualization to direct interventions.
   - Designs and delivers affective, cognitive, and behavioral interventions.

Comments:

9) Therapeutic Alliance  
   Rating 1-5
   - Employs core conditions of the counseling relationship: empathy, unconditional positive regard and authenticity.
   - Shows acceptance of client ambivalence about counseling and change.
Recognizes value of processing client-therapist relationship including differences, conflicts, and empathic failures.

Facilitates stages of counseling process—engagement, working, consolidation, termination.

Comments:

10) Core Counseling Skills and Techniques Rating 1-5

Demonstrates competent use of the following:

- Attending behavior
- Display of warmth, genuineness, and caring
- Amplifying client strengths
- Minimal encouragers
- Normalizing
- Open-ended questions
- Succinct language
- Pacing/Timing
- Reflections of thought and feeling
- Summarizing
- Tolerating silence
- (Re)focusing
- Self-disclosure
- Underlining
- Highlighting inconsistencies

Comments:

11) Multicultural and Diversity Integration Rating 1-5

- Utilizes suitable questioning to ascertain client worldview and level of acculturation.
- Demonstrates comfort level discussing and processing differences with clients initially and throughout the stages of therapy.
- Adapts treatment goals, techniques, style, and interventions to reflect an understanding of client in his or her cultural context.
- Brings diversity issues into supervision, including discussion of personal reactions to client-therapist differences.
Understands biases in the larger system around mental health diagnosis, ability to access services and overall oppression.

Understands how oppression may impact client.

Demonstrates awareness of sexual orientation, gender and racial identity development.

Demonstrates ability to work within client’s respective belief system, value system, and worldview while recognizing personal beliefs, values, and worldview.

Displays a strong commitment to continued personal growth in multicultural competence.

Comments:

SECTION 3: COUNSELOR IDENTITY DEVELOPMENT

12) Evaluation of Self as Professional Counselor

- Demonstrates interest in improving counseling skills through reviewing videotapes and utilizing professional resources including supervisors, peers, texts and journals.
- Assesses level of consonance and dissonance with client.
- Demonstrates awareness of impact on others and shows ability to use flexibility and non-defensiveness in addressing issues and/or conflicts.
- Shows awareness of transference and counter-transference issues with clients and is willing to examine them.

Comments:

13) Self-Knowledge

- Demonstrates knowledge and introspection regarding personal background and belief system in regard to culture, ethnicity, and diversity, and recognizes how these may influence counseling process.
- Demonstrates openness to self-reflection and growth through seeking feedback and engaging in personal therapies such as art therapy, music therapy, and psychotherapy.
- Demonstrates tolerance for fallibility in self and others.
- Shows healthy boundaries between professional and personal life, including emphasis on self-care.

Comments:
14) **Couple and Family Skills and Techniques**

**Rating 1-5**

**Conceptualization**
- Conceptualizes clients in a systemic rather than individualistic fashion.
- Understands how differences in client background may impact their beliefs around relationship dynamics.
- Empowers clients and their relational systems to establish effective support structure.
- Recognizes strengths, limitations, and contraindications of specific therapy models, including the risk of harm associated with models that incorporate assumptions of family dysfunction, pathogenesis, or cultural deficit.

**Skills and Techniques**
- Works towards joining with all the people in the counseling room.
- Engages each member through treatment process and balances participation as appropriate.
- Defuses intense and chaotic situations to enhance emotional safety of all participants.
- Utilizes co-therapist relationship as a model for effective communication.
- Facilitates client communication with each other instead of through therapist as suitable.
- Keeps emphasis away from “problem of the week” and focus on underlying themes.
- Assesses risk of domestic violence and takes appropriate action (e.g., safety plan, consult with supervisor).

**Comments:**

15) **Play Therapy**

**Rating 1-5**

**Conceptualization**
- Assess child’s social and cognitive development and designs suitable interventions.
- Views the child in a full systemic context, including academic, family, social, cultural..
- Articulates difference in direct and nondirective play therapy styles.
- Works toward understanding underlying feelings/cognitions behind behaviors.
- Understands role as play therapist with child.

**Skills & Techniques**
- Joins successfully with child.
Uses developmentally suitable child-friendly language.

Demonstrates ability to be playful.

Utilizes metaphor through play.

Designs and implements techniques as appropriate (e.g., puppets, sand tray, art).

Includes other systems as appropriate (e.g., family, school, community, mentors).

Comments:

SCORING CRITERIA AND GUIDELINES

The final rating for practicum performance will be based on the student’s performance level at the conclusion of the course (rather than based on an average of all of the student’s performances during the semester). Thus, the two earlier ratings (i.e., initial review and midterm evaluation) are considered formative in purpose. For the final overall rating, the supervisor will make a holistic judgment using the individual category scores (e.g., group supervision) as a guide.

CATEGORY RATING FOR INITIAL AND MIDTERM EVALUATION

5. Advanced: Student demonstrates consistent and insightful mastery in all areas.
4. Proficient: Student demonstrates consistent mastery in all key areas.
3. Developing: Student demonstrates inconsistent mastery across areas.
2. Needs Improvement: Student does not demonstrate mastery of many key areas.
1. Unacceptable: Student does not demonstrate mastery in most areas.

OVERALL RATING FOR FINAL EVALUATION

☐ 5 Advanced (Green Light to Internship)
☐ 4 Proficient (Green Light to Internship, with areas identified for development)
☐ 3 Developing (Yellow Light to Internship, pending completion of improvement plan)
☐ 2 Needs Improvement (Red light for Internship, probationary status)
☐ 1 Unacceptable (or does not provide evidence)

General Comments:

Student Name: _____________________________________________________________
Student Signature: _____________________________________________________________________ Date  ______________________
Supervisor Name _________________________________________________________________
Supervisor Signature: _____________________________________ Date  ______________________
INTAKE PROCESS

Keep in mind this may be the clients’ first contact with the clinic. Having a positive experience is very important to their continued treatment.

You can help the client have a positive experience by focusing on the person and using the paperwork as a guide. Be familiar with the forms before you meet with the client so that you will not be sifting through paperwork while they are telling their story. It is very important for the new client to feel heard and understood during the intake.

Be aware that, for many clients, coming to therapy for the first time is a very difficult step, which they may have been working towards for quite some time.

Be aware that some clients may not be appropriate for a student and/or the clinic (e.g. active psychosis, high risk of suicide, high risk of violence, active domestic violence, and severe untreated substance abuse). All situations are different and if any of these issues arise, take a break and consult with the attending supervisor. Sometimes a referral will be made in the intake if the person is clearly not appropriate. If the person is a UCD student, then a licensed clinician may see them.

Paperwork

Receptionists will give the following paperwork to clients when they arrive

1) Blue Emergency Information Card
2) Client Information Form
3) Financial Agreement
4) Green Disclosure Forms (two copies, one for the client to take and one for the file)

After the client has filled out and returned the above paperwork, add the client’s Initial Contact Form from the binder at the front desk and a blank Intake Form and give the clipboard to the Intake Counselor.

Steps

Step 1 Greet your client in the lobby.

Step 2 Begin by reviewing confidentiality (Note: confidentiality can be broken if there is concern that the client is at risk for harming self or others, in cases of child or elder abuse, or if the information is court-ordered). Make sure they have read and signed the disclosure form and see if they have any further questions. Remember to sign the disclosure form yourself.

Step 3 Explain the way the clinic operates including: treatment team, one-way mirror, phone calls, mid-session breaks, and videos. Be sure they understand how confidentiality applies. (Tapes for example, are only used for learning purposes, are kept under lock and key, are frequently taped over, and are erased at the end of the semester.) If they have objections to the procedures, see if you can explore the issue with them. One benefit of our clinic is that clients receive the advantage of several minds working in their best interest. If they refuse, and they are a UCD student, then they can see a clinician. However, clinicians’ schedules are less flexible and there may be a waiting list.

Step 4 Look over the financial agreement and be sure they understand their obligation, if any. UCD students get 10 free sessions per academic year (from July through June of the following year). Remember to sign and date the agreement.
Step 5  Make sure information is complete on the client information form and the blue emergency card.

Step 6  Make sure the client understands that the purpose of the intake is to gather current and historical information so that we can have as much information as possible regarding their situation in order to best meet their treatment needs. The outcome of the intake may be either to refer the client in to the counseling center to be seen by a student therapist, or a clinician or they may be referred out to another agency.

Step 7  What brought them in?

Gather as much information as you can about the description of the problem. Be curious. Offer empathy and yet keep in mind you will probably not be the therapist. Offering validation and hope where appropriate can be very helpful. This is where you will likely spend the most time during the intake.

Shift back to the form questions when you have a clear sense of the problems. Be sure to have familiarized yourself with the form, it will be very helpful to you at this point.

Always keep in mind that it is often difficult to talk to a stranger about one’s problem. It can be very helpful to acknowledge the client’s process, in a sincere way, during, or at the end of the intake.

Step 8  Explain that the information will be passed on to the clinic director to assess whether the counseling center can meet the client’s needs. If the client is referred in to the counseling center, someone should call them in a few days to set up an appointment. If the client is referred out, they will be contacted and provided with referral information.

Step 9  Once you have completed the intake, check in with the supervisor behind the glass with any questions and for feedback regarding your intake. (Remember you can always break if you are having difficulty during an intake or if you think a referral may be necessary.)

Step 10 Place all completed intake information in the Clinic Director’s box in the Administrative Assistant’s office.

Quick Reference Intake Checklist

___ Welcome client to counseling center and explain the intake process.
___ Review confidentiality and limitations to confidentiality.
___ Explain training component of the counseling center.
___ Do they want a clinician or trainee?
___ Does client have questions about disclosure form?
___ Has the client signed the disclosure form?
___ Give client copy of disclosure form.
___ What brought the client into the center?
___ Be sure to complete all aspects of intake questionnaire.
Discuss limits of confidentiality with client

**General Description of Presenting Problems:**
- Obtain details (including what happened, who is involved, when did it start)
- List Symptoms (intensity/frequency/duration)

What prompted you to seek counseling now?

What would you like to accomplish through counseling? (e.g. treatment goals)
1) ____________________________________________________________
   ____________________________________________________________
2) ____________________________________________________________
   ____________________________________________________________
3) ____________________________________________________________
   ____________________________________________________________
Inform client that you will be asking a number of detailed questions regarding their history in order to gather background information.

**Previous Mental Health Treatment:**

**History of mental health therapy:**

<table>
<thead>
<tr>
<th>Type</th>
<th>Date(s)/Duration</th>
<th>Issues discussed in treatment</th>
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Diagnosis (if known): ____________________________

**History of psychiatric hospitalizations:**

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<thead>
<tr>
<th>Date(s)/Duration</th>
<th>Reason for hospitalization</th>
<th>Treatment received</th>
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**Psychotropic medication:**

**Current medication(s)**

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<tr>
<th>Current medication(s)</th>
<th>Dosage</th>
<th>Prescribing Doctor</th>
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**Past medication(s)**

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<th>Dosage</th>
<th>Prescribing Doctor</th>
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What was helpful or not helpful about prior treatment?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________
**High Risk Factors:**

**Substance Use/Abuse:**

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<tr>
<th>Alcohol</th>
<th>Amount/Frequency</th>
<th>Recent changes in use</th>
<th>Period of heaviest use (when/amount)</th>
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<tr>
<th>Tobacco</th>
<th>Amount/Frequency</th>
<th>Recent changes in use</th>
<th>Period of heaviest use (when/amount)</th>
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<th>Illicit Drugs</th>
<th>Type of Drug</th>
<th>Amount/Frequency</th>
<th>Recent changes in use</th>
<th>Period of heaviest use (when/amount)</th>
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<th>Prescription Drugs</th>
<th>Type of Drug</th>
<th>Amount/Frequency</th>
<th>Recent changes in use</th>
<th>Period of heaviest use (when/amount)</th>
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**Have you ever thought that your substance use was a problem?** (Describe client’s insight into pattern or behavior of substance abuse)

____________________________________________________________________________________

____________________________________________________________________________________

**History of substance abuse treatment**

<table>
<thead>
<tr>
<th>Date(s)/Duration</th>
<th>Name of treatment center</th>
<th>Treatment received</th>
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**Sleep Patterns:** (Amount, quality, disruptions, recent change)

____________________________________________________________________________________

**Eating Patterns:** (Amount; recent weight gain/loss; recent change; history of binging/purging/restricting/overexercise; has your eating pattern ever been a problem for you?)

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
**Energy Level:** How is your level of energy currently? Any recent changes? (Energy; motivation; concentration/attention)

___________________________________________________________________________________

___________________________________________________________________________________

**Mood Assessment:**

How would you describe your overall mood?

____________________________________________________________________________________

Any recent changes? □ Yes □ No

If yes, describe: ________________________________________________________________

Do you maintain interest in activities you normally enjoy? □ Yes □ No

If no, describe: ________________________________________________________________

Have you ever experienced a time where you had:

- extremely high levels of energy to the point of not needing much sleep at all? □ Yes □ No
  
  If yes, describe: ________________________________________________________________

- impulsive behaviors? □ Yes □ No
  
  If yes, describe: ________________________________________________________________

- racing thoughts? □ Yes □ No
  
  If yes, describe: ________________________________________________________________

- Unusual increase in creative abilities? □ Yes □ No
  
  If yes, describe: ________________________________________________________________

Have you ever experienced these behaviors (listed above) at the same time? □ Yes □ No

If yes, describe: ________________________________________________________________

**Anxiety Assessment:**

How would you describe your level of anxiety?

____________________________________________________________________________________

Any recent changes? □ Yes □ No

If yes, describe: ________________________________________________________________

Does worrying too much impact your ability to accomplish things you want (i.e. School work, travel, social relationships)? □ Yes □ No

If yes, describe: ________________________________________________________________

Have you ever experienced a panic attack? □ Yes □ No

If yes, describe: ________________________________________________________________

Any unusual fears? □ Yes □ No

If yes, describe: ________________________________________________________________
Suicidal Ideation:
Current suicidal thoughts  □ Yes  □ No
If yes, describe: ________________________________________________________________
______________________________________________________________________________
Current plan for suicide  □ Yes  □ No
If yes, describe (include access to method): _________________________________________
If yes, what would keep you from hurting yourself (reasons to live)? __________________
______________________________________________________________________________
Past suicidal thoughts  □ Yes  □ No
If yes, describe: ________________________________________________________________
______________________________________________________________________________
Past attempt(s)  □ Yes  □ No
Describe (include number of attempts, age, method, hospitalization):
If yes, describe: ________________________________________________________________
______________________________________________________________________________

Homicidal Ideation:
Current homicidal thoughts  □ Yes  □ No
If yes, describe: ________________________________________________________________
______________________________________________________________________________
Current plan for violence  □ Yes  □ No
If yes, describe (include access to method): _________________________________
IF YES, What would keep you from hurting someone else? _________________________
______________________________________________________________________________
Availability of methods  □ Yes  □ No
If yes, describe: ________________________________________________________________
Past homicidal thoughts  □ Yes  □ No
If yes, describe: ________________________________________________________________
______________________________________________________________________________
History of past attempts of homicide or violence  □ Yes  □ No
Describe (include number of attempts, age, method, outcome):
If yes, describe: ________________________________________________________________
Self Injurious Behaviors (cutting, hitting oneself, extracting hair to excess, head banging, biting, burning, scratching self in excess):

Have you ever engaged in self injurious behaviors? □ Yes □ No

If yes, what? _________________________________________________________________________

If yes, when? _________________________________________________________________________

If yes, how did you stop? _____________________________________________________________
____________________________________________________________________________________

Any current self injurious behaviors or thoughts? __________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Present or History of Domestic Violence: (Current/past conflicts involving physical contact—hitting, slapping, physical threats, blocking exits—verbal abuse, or emotional abuse; include degree of severity; perceived degree of danger)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Present or History of Traumatic Experiences: (Sexual trauma, life challenging illness, accidents, violence, etc.)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Background Information/History:

Family History: (Describe relationships among family members, where born/raised, parents/siblings—marriage/divorce/relationship/support, family history of mental illness/suicide, family history substance abuse, childhood abuse/trauma/loss, or any other relevant family information)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

List names of family members:
Name   Relationship   Name   Relationship
_________________  _______________________  _________________  ________________________
_________________  _______________________  _________________  ________________________
Relationship Status/Social Support: (Current significant relationship, marriage/divorce, children, friendships)
____________________________________________________________________________________
____________________________________________________________________________________

Academic/Occupational Status: (Academic performance, current employment/job performance)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Medical Status: (Description of overall health, chronic/major illnesses, prescription drugs, hospitalizations)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Legal Status: (Court-ordered counseling, Social Services involvement, other legal involvement)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Ethnic/cultural identity: (How do you identify yourself ethnically/culturally? What would you like your counselor to know about your ethnic/cultural identity?)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Sexual orientation concerns or problems: (How do you identify yourself sexually? What would you like your counselor to know about your sexuality?)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Religion/spirituality concerns or problems: (How do you identify yourself religiously/spiritually? What would you like your counselor to know about religion/spirituality?)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Describe your personal strengths:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Other relevant information:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Intake Completed By:  _______________________________________________________________

For use by clinician (after completion of intake with client):

Behavioral Observations:

Behavior (description, manner, posture, dress, etc.)

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Affect/Mood

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Speech (tone of voice, style, rate and rhythm)

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Disposition:

Date Case Assigned: ______________

Name of Counselor: __________________________________________________ Date: ______________

Referral to Outside Agency: ____________________________________________ Date: ______________

Clinical Coordinator’s Signature: ________________________________________ Date: ______________

Please note all contacts and attempted contacts, along with a brief description of the nature of the contact.

____________________________________________________________________________________
____________________________________________________________________________________
Discuss limits of confidentiality with client

**General Description of Presenting Problems:**

- Obtain details (including what happened, who is involved, when did it start)
- List Symptoms (intensity/frequency/duration)

Partner 1: __________________________________________________________

__________________________________________________________

__________________________________________________________

Partner 2: __________________________________________________________

__________________________________________________________

What prompted you to seek counseling now?

Partner 1: __________________________________________________________

__________________________________________________________

Partner 2: __________________________________________________________

__________________________________________________________

What have you done to try and remedy the problem?

Partner 1: __________________________________________________________

__________________________________________________________

Partner 2: __________________________________________________________

__________________________________________________________

Are there times when the problem is not as bad or times when it is worse?

Partner 1: __________________________________________________________

__________________________________________________________

Partner 2: __________________________________________________________

__________________________________________________________
What would you like to accomplish through counseling? (E.g. treatment goals)

Partner 1: ______________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Partner 2: ______________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Inform clients that you will be asking a number of detailed questions regarding their history in order to gather background information

**Previous Mental Health Treatment:**

**History of mental health therapy:**

<table>
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<th>Type</th>
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<td>Partner 1:</td>
<td></td>
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</tr>
<tr>
<td>Partner 2:</td>
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</tbody>
</table>

What was helpful or not helpful about prior treatment?

Partner 1: ______________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Partner 2: ______________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

**History of psychiatric hospitalizations:**

<table>
<thead>
<tr>
<th>Date(s)/Duration</th>
<th>Reason for hospitalization</th>
<th>Treatment received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner 1:</td>
<td></td>
<td></td>
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<tr>
<td>Partner 2:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mental Health related medication:**

<table>
<thead>
<tr>
<th>Current medication(s)</th>
<th>Dosage</th>
<th>Prescribing Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner 1:</td>
<td></td>
<td></td>
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<tr>
<td>Partner 2:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Past medication(s)</th>
<th>Dosage</th>
<th>Prescribing Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner 1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner 2:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Any family members with a history of mental health issues? Including suicide attempts/hospitalizations?
Partner 1: _________________________________________________________________________________
__________________________________________________________________________________________
Partner 2: ________________________________________________________________________________
__________________________________________________________________________________________

**High Risk Factors:**

**Substance Use/Abuse:**

**Alcohol**

<table>
<thead>
<tr>
<th>Amount/Frequency</th>
<th>Recent changes in use</th>
<th>Period of heaviest use (when/amount)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner 1:</td>
<td></td>
<td></td>
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<tr>
<td>Partner 2:</td>
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<td></td>
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</tbody>
</table>

**Tobacco**

<table>
<thead>
<tr>
<th>Amount/Frequency</th>
<th>Recent changes in use</th>
<th>Period of heaviest use (when/amount)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner 1:</td>
<td></td>
<td></td>
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<tr>
<td>Partner 2:</td>
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<td></td>
</tr>
</tbody>
</table>

**Other Drugs**

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Amount/Frequency</th>
<th>Recent changes in use</th>
<th>Period of heaviest use (when/amount)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner 1:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner 2:</td>
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</tbody>
</table>

**Recreational use of Prescription Drugs**

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Amount/Frequency</th>
<th>Recent changes in use</th>
<th>Period of heaviest use (when/amount)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner 1:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Partner 2:</td>
<td></td>
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</tbody>
</table>

Have you or anyone else ever thought that your substance use was a problem? (Describe client’s insight into pattern or behavior of substance abuse)
Partner 1: _________________________________________________________________________________
__________________________________________________________________________________________
Partner 2: ________________________________________________________________________________
__________________________________________________________________________________________
History of substance abuse treatment

<table>
<thead>
<tr>
<th>Date(s)/Duration</th>
<th>Name of treatment center</th>
<th>Treatment received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner 1:</td>
<td></td>
<td></td>
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<tr>
<td>Partner 2:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any Family member with history of substance abuse?

Partner 1: __________________________________________________________

Partner 2: __________________________________________________________

Sleep Patterns: (Amount, quality, disruptions, recent change)

Partner 1: __________________________________________________________

Partner 2: __________________________________________________________

Eating Patterns: Has your eating pattern ever been a problem for you? (amount; recent weight gain/loss; recent change; history of bingeing/purging/restricting/over exercise)

Partner 1: __________________________________________________________

Partner 2: __________________________________________________________

Energy Level: How is your level of energy currently? Any recent changes? (Energy; motivation; concentration/attention)

Partner 1: __________________________________________________________

Partner 2: __________________________________________________________
### Mood Assessment:

<table>
<thead>
<tr>
<th></th>
<th>Partner 1</th>
<th>Partner 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you describe your overall mood?</td>
<td>______________________________________________________________________</td>
<td>______________________________________________________________________</td>
</tr>
<tr>
<td></td>
<td>______________________________________________________________________</td>
<td>______________________________________________________________________</td>
</tr>
<tr>
<td>Any recent changes?</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes, describe:</td>
<td>______________________________________________________________________</td>
<td>______________________________________________________________________</td>
</tr>
<tr>
<td>Do you maintain interest in activities you normally enjoy?</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If no, describe:</td>
<td>______________________________________________________________________</td>
<td>______________________________________________________________________</td>
</tr>
<tr>
<td>Have you ever experienced a time where you had: extremely high levels of energy to the point of not needing much sleep at all?</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes, describe:</td>
<td>______________________________________________________________________</td>
<td>______________________________________________________________________</td>
</tr>
<tr>
<td>Impulsive behaviors?</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes, describe:</td>
<td>______________________________________________________________________</td>
<td>______________________________________________________________________</td>
</tr>
<tr>
<td>Racing thoughts?</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes, describe:</td>
<td>______________________________________________________________________</td>
<td>______________________________________________________________________</td>
</tr>
<tr>
<td>Increase in creative abilities all occurring at the same time?</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes, describe:</td>
<td>______________________________________________________________________</td>
<td>______________________________________________________________________</td>
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</tbody>
</table>
## Anxiety Assessment

<table>
<thead>
<tr>
<th>Partner 1</th>
<th>Partner 2</th>
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</thead>
</table>
| **How would you describe your level of anxiety?**  
_________________________ | **How would you describe your level of anxiety?**  
_________________________ |
| **Any recent changes?**  
☑ Yes ☑ No | **Any recent changes?**  
☑ Yes ☑ No |
| If yes, describe: __________________________________________________________________ | If yes, describe: __________________________________________________________________ |
| **Does worrying too much impact your ability to accomplish things you want (i.e. School work, travel, social relationships).**  
☑ Yes ☑ No | **Does worrying too much impact your ability to accomplish things you want (i.e. School work, travel, social relationships).**  
☑ Yes ☑ No |
| If yes, describe: __________________________________________________________________ | If yes, describe: __________________________________________________________________ |
| **Have you ever experienced a panic attack?**  
☑ Yes ☑ No | **Have you ever experienced a panic attack?**  
☑ Yes ☑ No |
| If yes, describe: __________________________________________________________________ | If yes, describe: __________________________________________________________________ |
| **Any unusual fears?**  
☑ Yes ☑ No | **Any unusual fears?**  
☑ Yes ☑ No |
| If yes, describe: __________________________________________________________________ | If yes, describe: __________________________________________________________________ |

## Suicidal Ideation:

<table>
<thead>
<tr>
<th>Partner 1</th>
<th>Partner 2</th>
</tr>
</thead>
</table>
| **Current suicidal thoughts**  
☑ Yes ☑ No | **Current suicidal thoughts**  
☑ Yes ☑ No |
| Describe: __________________________________________________________________ | Describe: __________________________________________________________________ |
| **Current plan for suicide**  
☑ Yes ☑ No | **Current plan for suicide**  
☑ Yes ☑ No |
| Describe (include access to method): __________________________________________________________________ | Describe (include access to method): __________________________________________________________________ |
| **IF YES, what would keep you from hurting yourself (reasons to live)?**  
_________________________ | **IF YES, what would keep you from hurting yourself (reasons to live)?**  
_________________________ |
| **Past suicidal thoughts**  
☑ Yes ☑ No | **Past suicidal thoughts**  
☑ Yes ☑ No |
| Describe: __________________________________________________________________ | Describe: __________________________________________________________________ |
| **Past attempt(s)**  
☑ Yes ☑ No | **Past attempt(s)**  
☑ Yes ☑ No |
| Describe (include number of attempts, age, method, hospitalization): __________________________________________________________________ | Describe (include number of attempts, age, method, hospitalization): __________________________________________________________________ |
| **Do you engage in any current or past self-harming behaviors, such as cutting, burning, etc?**  
☑ Yes ☑ No | **Do you engage in any current or past self-harming behaviors, such as cutting, burning, etc?**  
☑ Yes ☑ No |
| Describe: __________________________________________________________________ | Describe: __________________________________________________________________ |
### Homicidal Ideation:

<table>
<thead>
<tr>
<th>Partner 1</th>
<th>Partner 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current homicidal thoughts</strong></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Describe:</td>
<td></td>
</tr>
<tr>
<td><strong>Current plan for violence</strong></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Describe (include access to method):</td>
<td></td>
</tr>
<tr>
<td><strong>IF YES, What would keep you from hurting someone else?</strong></td>
<td>Describe:</td>
</tr>
<tr>
<td><strong>Availability of methods</strong></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Describe:</td>
<td></td>
</tr>
<tr>
<td><strong>Past homicidal thoughts</strong></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Describe:</td>
<td></td>
</tr>
<tr>
<td><strong>History of past attempts of homicide or violence</strong></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Describe (include number of attempts, age, method, outcome):</td>
<td></td>
</tr>
</tbody>
</table>

### History of Domestic Violence: (Witness current/past conflicts involving physical contact—hitting, slapping, physical threats, blocking exits—verbal abuse, or emotional abuse; include degree of severity; perceived degree of danger) * Note: if there are any indications of current domestic violence split couple up and ask endangered partner if there are safety concerns or need for DV resources.

Partner 1: __________________________________________________________

Partner 2: __________________________________________________________

### History of Traumatic Experiences: (Sexual trauma, life challenging illness, accidents, violence, etc.)

Partner 1: __________________________________________________________

Partner 2: __________________________________________________________

COUNSELOR: TAKE BREAK
Family History: Describe the relationships of your family of origin. Has this changed over time?
Partner 1: ________________________________________________________________

Partner 2: ________________________________________________________________

Relationship History: Have you been previously married or in a very committed relationship? Any children from this relationship or previous relationships? (If children get names, ages, and where they reside). Has this changed over time?
Partner 1: ________________________________________________________________

Partner 2: ________________________________________________________________

Social Support: Describe your social support system outside the relationship.
Partner 1: ________________________________________________________________

Partner 2: ________________________________________________________________

Academic/Occupational Status: (Academic performance, current employment/job performance)
Partner 1: ________________________________________________________________

Partner 2: ________________________________________________________________

Medical Status: (Description of overall health, chronic/major illnesses, prescription drugs, hospitalizations)
Partner 1: ________________________________________________________________

Partner 2: ________________________________________________________________
Legal Status: Any current or past involvement with the legal system? (i.e. DUI, felony/misdemeanor)
Partner 1: _________________________________________________________________________________
__________________________________________________________________________________________
Partner 2: ________________________________________________________________________________
__________________________________________________________________________________________

Is this counseling court ordered?  Is social services involved?
☐ Yes ☐ No  ☐ Yes ☐ No

If yes; gather more information ________________________________________________________________
__________________________________________________________________________________________

Culture: How do you identify yourself culturally? Are there certain family customs or holidays that are important in your family? How does cultural identity impact your couple/family relationships?
Partner 1: _________________________________________________________________________________
__________________________________________________________________________________________
Partner 2: ________________________________________________________________________________
__________________________________________________________________________________________

Describe any concerns related to your sexual orientation: (gender identity, coming out, discrimination)
Partner 1: _________________________________________________________________________________
__________________________________________________________________________________________
Partner 2: ________________________________________________________________________________
__________________________________________________________________________________________

Religion/Spirituality: How do you identify yourself religiously/spiritually? Are there certain family customs or holidays that are important in your family? How does religion/spirituality impact your couple/family relationships?
Partner 1: _________________________________________________________________________________
__________________________________________________________________________________________
Partner 2: ________________________________________________________________________________
__________________________________________________________________________________________
Describe three strengths about yourself
Partner 1: _________________________________________________________________________________
__________________________________________________________________________________________
Partner 2: _________________________________________________________________________________
__________________________________________________________________________________________

Describe three strengths about your partner.
Partner 1: _________________________________________________________________________________
__________________________________________________________________________________________
Partner 2: _________________________________________________________________________________
__________________________________________________________________________________________

Other relevant information:
__________________________________________________________________________________________
__________________________________________________________________________________________
Intake Completed By: _____________________________________________________________________

For use by clinician (after completion of intake with client):

Behavioral Observations:
Behavior (description, manner, posture, dress, etc.)
__________________________________________________________________________________________
__________________________________________________________________________________________

Affect/Mood
__________________________________________________________________________________________

Speech (tone of voice, style, rate and rhythm)
__________________________________________________________________________________________

Disposition:

Date Case Assigned: ______________
Name of Counselor: _____________________________ Date: ____________________
Referral to Outside Agency: _____________________________ Date: __________________
Clinical Coordinator’s Signature: _____________________________ Date: __________________

Please note all contacts and attempted contacts, along with a brief description of the nature of the contact.
__________________________________________________________________________________________
__________________________________________________________________________________________
Intake Questionnaire for Minors

Thank you for bringing your son or daughter to counseling with us. In order to best serve your needs, it would be helpful if you would fill out the following questions. Your intake counselor will discuss the questions in further detail with you during the intake interview.

ARE THERE ANY CONCERNS WITH THE FOLLOWING?

- nightmares/sleeping problems
- aggression to animals
- aggression to people
- tics
- drugs/alcohol
- cutting
- hygiene difficulties
- bedwetting (or similar concerns)
- inconsolable tantrums
- anxiety
- speech/language concerns
- sexual concerns
- fearful
- eating concerns
- delayed developmental milestones: crawling, talking
- sensitivity to noise, touch, visual stimuli
- preoccupation with death/gore
- learning concerns
- fire setting
- truancy
- lying
- stealing
- breaking objects
- lack of respect for authority
- boundary problems with others

PLEASE DESCRIBE ANY CONCERNS FURTHER:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Intake for Minors

Discuss limits of confidentiality with Client.

Parent: Please tell us a description of the problem such as; what, who is involved, when did it start, etc.

Child: What is going on that brought you to counseling?

Parent: How do you think we can help your child?

Child: How do you think counseling can help you?

COUNSELOR: Refer to checklist and ask about any concerns

FAMILY DYNAMICS

Parent: Please characterize the nature of relationships among family members.

Child: How do people in your family get along?

Living Arrangements: 

Year of Divorce/Separation (if applicable): If separated or divorced, please describe parenting and visitation arrangements:

If divorced/separated, who has legal decision-making powers:

<table>
<thead>
<tr>
<th>HOUSEHOLD MEMBERS</th>
<th>RELATIONSHIP</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>
If more than one household

<table>
<thead>
<tr>
<th>HOUSEHOLD MEMBERS</th>
<th>RELATIONSHIP</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Parent: Please describe any other significant adults in your child’s life.
*Child: Who are other important grownups to you?*

__________________________________________________________________________________________
__________________________________________________________________________________________

Parent/Child: What does your family do together for fun?

__________________________________________________________________________________________
__________________________________________________________________________________________

Parent: What does your child enjoy doing in his or her spare time?
*Child: What do you like to do for fun?*

__________________________________________________________________________________________
__________________________________________________________________________________________

Parent: Describe your parenting style and approach to discipline. Do both parents have the same ideas regarding discipline?
*Child: What do your parents do when you break the rules?*

__________________________________________________________________________________________
__________________________________________________________________________________________

Parent: What are your child’s responsibilities at home?
*Child: Do you have chores at home?*

__________________________________________________________________________________________
__________________________________________________________________________________________

Parent: How does your child react to discipline?
*Child: What do you do when you get in trouble?*

__________________________________________________________________________________________
__________________________________________________________________________________________
Parent: How do you reward your child for good behavior?
Child: What happens when you do a good job following the rules?

SAFETY CONCERNS

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent: Is this counseling court ordered?</td>
<td></td>
</tr>
<tr>
<td>Parent: Is social services involved?</td>
<td></td>
</tr>
<tr>
<td>Parent: Is the situation urgent?</td>
<td></td>
</tr>
</tbody>
</table>
| Parent: Is your child or anyone in the family considering/threatening suicide?  
**Child: Are you thinking about hurting yourself? Is anyone in your family? Does anyone want to kill themselves?** |    |
| Parent: Is there a history of suicide attempts?  
**Child: Has anyone in your family tried to kill themselves before?** |    |
| Parent: Is there physical conflict present, such as hitting, pushing, slapping, blocking exits, physical threats, or any fear of these?  
**Child: Is anyone at home fighting with their fists?** |    |
| Parent: Is there other legal involvement?  
**Child: Have you or anyone else in your family been in trouble with the police?** |    |
| Parent: Is there a history of psychiatric hospitalization?  
**Child: Have you or anyone in your family gone to the hospital because they were extremely upset?** |    |
| Parent: Have there been any past significant traumas, losses, abuse history, or separations your child or family has experienced?  
**Child: Have you ever had anything really upsetting happen, like a car accident or scary event? Anyone close to you ever die? Has anyone ever hurt you?** |    |

IF YOU ANSWERED YES TO ANY OF THE ABOVE PLEASE EXPLAIN:

**COUNSELOR: PLEASE TAKE A MID SESSION BREAK HERE **

MENTAL HEALTH

Parent: Please tell us about any previous counseling experiences: whom, when, client reaction, outcome.  
**Child: Have you seen a counselor before? What was it like?**
Parent: How does your child express feelings: such as sadness or anger?
Child: How do you show people how you are feeling?
__________________________________________________________________________________________
__________________________________________________________________________________________

Parent: Are there any past or current issues of mental illness and/or substance abuse?
Child: Has anyone in your family use drugs or drink a lot? Anyone hurt themselves or anyone else?
__________________________________________________________________________________________
__________________________________________________________________________________________

MEDICAL HISTORY

Parent: How would you describe your child’s general health?
Child: Are you the type of kid who gets sick often? Do you have to take medicine for something a lot?
__________________________________________________________________________________________
__________________________________________________________________________________________

Parent: Has your child had any illnesses? Injuries? Surgeries? Head injuries? Hospitalizations?
Child: Have you ever been really sick and needed to go to the hospital?
__________________________________________________________________________________________
__________________________________________________________________________________________

Parent: Please list any past and/or present psychotropic medications. Include: name, dosage, reason
__________________________________________________________________________________________
__________________________________________________________________________________________

SCHOOL/COMMUNITY

GRADE ___________________ SCHOOL ____________________________

Parent: How is your child doing in school?
Child: How would your teachers describe you?
__________________________________________________________________________________________
__________________________________________________________________________________________
Would you say your school and neighborhood are safe?

School  YES _____  NO ______
Neighborhood  YES _____  NO ______
If no, please describe:
________________________________________________________________________

Parent: Has your child ever experienced discrimination?
Child: Has anyone ever picked on you about things you can’t help like skin color or size?
________________________________________________________________________
________________________________________________________________________

Parent: Are there issues impacting other family members or the family we have not yet discussed? If so, please describe.
Child: What things upset people in your family?
________________________________________________________________________
________________________________________________________________________

Parent: Tell us three strengths or talents your child possesses.
Child: What do you like about yourself?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

NAME OF PERSON INTERVIEWED_________________RELATIONSHIP TO CHILD_________________________
NTAKE COMPLETED BY______________________________________________________________________________________

Case Assigned: _____/_____/_____
Name of Counselor:____________________________________________   Date: :  _____/_____/_____  
Referred Out: _______________________________________________ Date: :  _____/_____/_____  
Agency Name: _______________________________________________ Date: :  _____/_____/_____  
Clinical Coordinator’s Signature: _________________________________ Date: :  _____/_____/_____  

Please note all contacts and attempted contacts, along with a brief description of the nature of the contact.
### Client File Checklist

(Forms need to be in the following order, **TOP to BOTTOM** as required for the file.)

**LEFT SIDE OF FILE:**

- _____ Transfer/Termination Summary
- _____ Any Written Correspondence
- _____ Release of Information
- _____ Phone Contact Log
- _____ Treatment Plan
- _____ Intake Face Sheet and Form
- _____ Initial Client Contact Form
- _____ Clinic Disclosure Form
- _____ Individual Counselor Disclosure Form
- _____ Parent/Guardian Authorization
- _____ Abuse Report
- _____ Life Pledge
- _____ Lethality Assessment
- _____ Financial Agreement

**RIGHT SIDE OF FILE:**

- _____ All Progress Notes  
  (Most recent on TOP)
- _____ All Case Notes

### SIGNATURES:

- **Counselor:** ________________________________  **Date:** ________________
- **Supervisor Signature:** ________________________________  **Date:** ________________
- **Clinic Director:** ________________________________  **Date:** ________________
Transfer/Termination Summary

Client/Family Name: ________________________________  Case Number: ____________

Source of Referral: __________________________________  Date First Seen: ___________

Client System's Presenting Problem:
__________________________________________________________________________________________
__________________________________________________________________________________________

Treatment Goal:
__________________________________________________________________________________________
__________________________________________________________________________________________

Treatment Objectives:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Case Process Summary:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Treatment Outcome:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Follow-up:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Counselors' Signature(s): ________________________________ Date: ____________

Clinical Supervisor's Signature: ________________________________ Date: ____________

Clinical Director's Signature: ________________________________ Date: ____________
Authorization to Release or Request Information

Date: _____________

I, ___________________________________, hereby authorize the staff of the CU Denver Student and Community Counseling Center to release and/or request the following information concerning me to and/or from:

________________________________________________________________________________

(Name of person, hospital/agency/company)

Street Address: __________________________________________________________________

City: __________________________________________ State: ________ Zip: ______________

Telephone: _____________________________________ Fax: ____________________________

The disclosure of information and records authorized herein is required for the following purpose:

- ☐ Education
- ☐ Legal
- ☐ Medical
- ☐ Psychiatric
- ☐ Psychological
- ☐ Other: __________________________

The specific type(s) of information to be disclosed are as follows:

- ☐ All records
- ☐ Admission and discharge summaries
- ☐ Presence in treatment
- ☐ Treatment plan
- ☐ Verbal and/or written progress
- ☐ Other: __________________________

This authorization shall remain valid until: ___________________________________________

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that this information may not be released to or received from any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid. The information disclosed and/or requested shall not be used for any purpose other than its intended use. I hereby release the CU Denver Student and Community Counseling Center and the above listed party from liability that may result from furnishing this information.

___________________________________________________________ __________________
Signature of Client or Responsible Party   Date

___________________________________________________________ __________________
Signature of Witness   Date
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Notes</th>
<th>Counselor</th>
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Client Name: ____________________________________  Case Number ____________

Presenting Problem/Definition:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Long Term Goals:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Short Term Goals/Objectives:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Interventions:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Counselor’s Signature: ___________________________ Date: ____________

Supervisor’s Signature: ___________________________ Date: ____________
Initial Contact Form

*Ask the client if he/she has been oriented to the clinic. If not: inform them of videotapes and one-way mirrors. Make sure to get client contact information first and if caller won’t supply, do not proceed.

Date of Contact: ____/____/____  Caller Name: _____________________________________________
Telephone # for Messages: ___________________________ Address: _____________________________________________
  o home  o work  o other ____________  Detailed Message?  o YES  o NO
Telephone # Calling From: ___________________________ ______________________________________________
  o home  o work  o other ____________  Detailed Message?  o YES  o NO

Is the Caller:   _____ CU-Denver Student   _____ DPS Student     _____ Community Member

How did you hear about us?
  ____  Saw flyer on campus  ____  UCD Website
  ____  Newspaper  ____  Banner in North Classroom
  ____  Referred by ____________________________  ____ Community outreach table
  ____  From class or professor  ____  Other ____________________________

Seen here before? ______       When?______________           (Look Up Case Number) __________________

What type of therapy are you seeking?
  ____ Individual Adult     ____ Individual Child     ____ Couples     ____ Family

Inform caller of limits to confidentiality: 1. Harm to self or others  2. Child abuse  3. Court order

*NOTE:  The Counseling Center does not accept clients that require court testimony from their counselor.

Brief description of presenting concern:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Is the client experiencing any safety concerns for themselves or for anyone in their family?  Yes _____     No _____

*If yes, please notify on call supervisor

Date Referral Given:          Name or Organization Referred:          Referral Phone Number:
_______________________________________________________________________________________

Intake Schedule

Scheduled By: _______________________________________________________________________________________
Intake Scheduled for: M  T  W  R  Date: _____/_____/_______  Time: _______  Room: _______________
Intake Scheduled with: _______________________________________________________________________________________

Date Referral Given:          Name or Organization Referred:          Referral Phone Number:
_______________________________________________________________________________________
Disclosure Form

Case # __________________

The Student and Community Counseling Center is a training facility sponsored by the Counseling Psychology and Counselor Education Program in the School of Education. The student counseling provided is under direct supervision of professional faculty and professionals in the field with many years of experience. The counselors are completing a master’s degree in counseling at the University of Colorado at Denver and Health Sciences Center. The student counselors are providing services on a semester basis as part of their clinical training experience under the supervision of an experienced mental health professional.

During your intake session, your counselor will ask you several questions about your current life as well as about your physical health, mental health, and family history. Some of the questions, especially those around suicide and trauma, may be stressful to answer. We ask these questions to assess if we need to help with immediate safety concerns and to determine if we have the skills and resources to provide you with the support you need. We respect your right not to answer. All information shared will be safeguarded to insure your privacy with the exceptions of confidentiality described later in this document.

UCD students may elect to be seen by either a student counselor or a licensed clinician. These students may also choose not to be observed by the treatment team or to be videotaped in which case they MUST be seen by a clinician or intern. UCD students are entitled to 10 free sessions during an academic year (July 1-June 30).

The Center has been established to provide an opportunity for you to discuss issues in your life which may be affecting your work, studies, relationships or family. The counseling offered is supportive and caring. Personal concerns, study issues, and career choices are all appropriate topics for the counseling approach. If you believe that this type of counseling does not suit your needs, referral to other agencies can be arranged.

The counselor assigned to those who are not UCD students will be available to meet with you through the current term. Every effort will be made to provide a new counselor in the following term if you believe it would be helpful. In cases where children are being seen, there may be a change in the student counselor if your child needs continued care.

Limitations of Services:
The Center is not able to provide 24 hour care, therefore the appropriate referrals are given to individuals (such as but not limited to: in-patient detox, acutely suicidal, homicidal, or psychotic) in need of more intensive treatment. In these cases supervisors will collaborate with the appropriate agencies in order to assure client safety. Some services may be requested that are beyond the scope of our competencies such as forensic assessments, child custody evaluations, or evaluations for disability accommodations. In these cases referrals will be made to other agencies. Because the Center operates on a semester schedule, immediate treatment cannot be guaranteed if you contact us near the end of a semester. If immediate assignment becomes a problem, we will inform you of alternative agencies that provide similar services so that you are not inconvenienced. If you desire, you will be placed on a waiting list for the following semester. The Center has specific operating hours, and does not provide after hours emergency services. In the event of such an emergency, contact your local mental health center or emergency room, or call the COMITIS Helpline at 303-343-9890 or Denver Health Medical Center at 303-436-6266.

We hope your association with the Center is helpful. During the semester, you may be asked for your perceptions of the counseling you are receiving. If you have any suggestions or concerns regarding the services we provide, please feel free to telephone the Center office at 303-556-4372.
Counseling Sessions:
The Student and Community Counseling Center provides counseling services for UCD students and Denver Public School students free-of-charge up to 10 sessions. Other campus students, campus personnel and the community-at-large may be seen on a sliding scale fee basis. SHOULD YOU BE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT, PLEASE CONTACT THE CENTER 24 HOURS IN ADVANCE TO AVOID BEING CHARGED FOR THE SESSION. The Center telephone number is 303-556-4372.

Video recordings, as well as observation through one-way glass, are utilized by students and staff of the Center. Observation and taping are conducted for each counseling session (except those with a Licensed Clinician) and are used for training and research purposes only. Students who have signed confidentiality pledges may observe counseling sessions. Any observation write-ups will focus on counselor skills and will not include specific identifying client information. You may be asked to complete certain evaluative instruments which will be used in research to increase the effectiveness of counseling. All information received on these instruments will be confidential. Participation is optional.

If you are seen both in individual therapy and in couple or family therapy, the same treatment team may see you in both sessions. Regular mid-session breaks and/or intercom calls from the Supervisor will allow team involvement. It is our intent to give you quality service that includes the expertise of both your counselor and the treatment team.

Because this is a graduate training program, matters such as child custody, court testimony, and evaluations are beyond the scope of our mission. It is the Center’s policy that our student counselors DO NOT testify in court. It is not in your best interests to be served by the Center if you wish to use our student counselors to testify for you in court. Student counselors are not qualified to serve as “expert witnesses.” If you desire therapy, and are in litigation and needing expert testimony, please inform your student counselor in the first session (or as soon as you know), so that an appropriate referral can be made for you.

In situations of divorce or separation, when treatment of minors is requested within the context of family and/or individual therapy, unless the custodial parent has provided legal proof of sole custody, both parents must sign the clinic disclosure form and the consent to treat minors form.

Confidentiality:
In order to protect client confidentiality, we adhere to the following procedures:

(A) Written, telephone, or personal inquiries about clients will not be acknowledged. The client must sign a Release of Information Form before any information about you will be given to anyone outside the Center. If you are in couple and/ or family therapy, each adult involved in therapy must sign a Release of Information Form before any information is released.

(B) All records, tapes and/ or other identifying materials are kept in the strictest confidence and are only reviewed by your counselor and the treatment team. Faculty Supervisors, Licensed Clinicians, and students who know you personally and/ or professionally are not allowed to observe your session or review any of your materials.

(C) IMPORTANT! Colorado state law requires exceptions to confidentiality as follows:
1. Indication by the counselee of intent to physically harm himself or herself or another human being. In such cases the counselor has a duty to warn either (a) the person who is likely to suffer the result of harmful behavior. (b) that person’s family, (c) the family of the counselee who intends to harm himself/ herself and/ or (d) the proper authorities.
2. Alleged child or elder abuse, in which case the counselor has a responsibility to notify the appropriate authorities of such allegations.
3. A court order requiring release of information.
4. Information to probation officers, the courts (in cases of court mandated or court referred therapy), and/ or social services as deemed necessary.
5. Information to and from psychiatrists who are seeing clients referred by the center as deemed necessary.

The Student Counselor or Licensed Clinician will, whenever possible, share with the counselee the intent to notify relatives or authorities. In cases of threatened homicide or suicide, every effort will be made to resolve
the issue before any other action is taken. In couple and/or family therapy, it is the counselor’s prerogative, upon his/her professional judgment, to disclose information shared individually in or out of a session.

**Consent to Evaluation/Treatment and Consent for Staff Consultation**
I hereby apply for evaluation, treatment, or other services offered to me by the UCD. I acknowledge that no guarantees can be made to me as to the results of treatment.

I authorize discreet verbal communication between the UCD Student and Community Counseling Center and the Auraria Health Center. This may include consultation with a psychiatrist should that be necessary in the course of my counseling in order to provide appropriate services and referrals. In the case of a threat or harm to self or others, I understand that my counselor may need to notify others on a need to know basis.

**Counseling risks and rights**
You have the right to terminate therapy and/or get a second opinion at any time. If you chose to terminate therapy, we do request that you discuss your decision with your counselor. We strive to provide the highest quality service at the Center, and encourage feedback. Please feel free to call the Clinic Coordinator at 303-556-4372.

It is important to understand that there may be a potential for emotional strain, stress, and life changes as a result of therapy.

**Clients rights**
You are entitled to:
- information about the methods of therapy, the duration of therapy, and the fee structure.
- seek a second opinion from another counselor/agency.
- prevent the electronic recording of any part of the session without prior written approval.
- terminate counseling at any time without obligation.
- release any part of your record at any time from your files to any person you designate.
- If the counselor is seeing you as a couple or as a family, all individuals involved in the session must give prior permission for release of information.

The practice of both licensed and unlicensed persons working in the field of psychotherapy is regulated by the Department of Regulatory Agencies. Any complaint about your counselor should be addressed to: State Grievance Board, 1560 Broadway Street, #1340, Denver, CO 80202; (303) 894-7766.

In a professional relationship, sexual intimacy is never appropriate and it is illegal in the state of Colorado. If sexual intimacy occurs, it should be reported to the State Grievance Board.

The information above must be provided to all counselees according to Colorado Law. If you have any questions about this information, please contact the Center office at 303-556-4372 or the Colorado Mental Health Grievance Board.

I have read and understand the above and agreed to participate in counseling.

Client Name (printed) _____________________________________________________
Client Signature ___________________________________  Date  _________________

Client Name (printed) _____________________________________________________
Client Signature __________________________________   Date __________________

If the client is a minor:
Name of Minor (printed) ___________________________________________________
Parent or Guardian Name (printed) ___________________________________________
Parent or Guardian Signature _________________________  Date _________________

Counselor Signature:

Student Counselor Name (printed) ___________________________________________

Student Counselor Signature __________________________  Date _________________

Or

Licensed Clinician Name (printed) ___________________________________________

Licensed Clinician Signature __________________________  Date _________________

VIDEOTAPE CONSENT FORM:
I/We the undersigned, give the Center my/our permission to use videotapes of me/us for supervisory purposes only. Supervision includes consultation with members of a treatment team.

____________________________________________ __________________
Client Date

____________________________________________ __________________
Client Date

ATTENTION:
The Counseling Center will be closed for school breaks and holidays the following days during the 2008-2010 school year:

- Break between Fall and Spring Sessions: December 11 – January 24, 2008
- Break Between Spring and Summer Sessions: May 13 – May 29, 2008
- Break between Summer and Fall Sessions: July 29 – August 20, 2008
- Labor Day: September 1, 2008
- Fall Break: November 24 – 30, 2008
- Thanksgiving: November 27, 2008
- Break between Fall and Spring Sessions: December 9 – January 22, 2008
- Spring Break: March 16 – 22, 2008
- Break Between Spring and Summer Sessions: May 12 – May 28, 2008
- Break between Summer and Fall Sessions: August 4 – August 19, 2008
- Labor Day: September 7, 2008
- Fall Break: November 24 – 30, 2008
- Thanksgiving: November 27, 2008
- Break between Fall and Spring Sessions: December 9 – January 22, 2009
- Spring Break: March 16 – 22, 2009
- Break Between Spring and Summer Sessions: May 12 – May 28, 2009
- Break between Summer and Fall Sessions: July 4 – August 19, 2009
- Labor Day: September 7, 2009
- Fall Break: November 23 – 29, 2008
- Thanksgiving: November 26, 2009
- Break between Fall and Spring Sessions: December 8 – January 21, 2010

____________________________________________ _________________
Client Date

____________________________________________ __________________
Client Date
Individual Counselor Disclosure Form

I have a Bachelor of Arts degree in XXXX from XXXXX, in XXXXX. I am in the process of attaining my masters degree in Counseling Psychology and Counselor Education at the University of Colorado Denver. I am under the supervision of XXXXX license XXXXX.

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy.

The agency within the department that has responsibility specifically for licensed and unlicensed psychotherapists is the State Grievance Board, 1560 Broadway, Suite 1340, Denver, CO, 80202, 303.894.7766.

Client Rights and Important Information

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure.

b. You can seek a second opinion from another therapist or terminate therapy at any time.

c. In a professional relationship (such as ours), sexual intimacy is NEVER appropriate.

d. Generally speaking, information provided by and to a client during therapy sessions with either a certified school psychologist, a licensed clinical social worker (LCSW), a licensed marriage and family therapist (LMFT), a licensed professional counselor (LPC), a licensed psychologist, or an unlicensed psychotherapist practicing under the supervision of a licensed psychotherapist is legally confidential.

Information disclosed to a licensed clinical social worker (LCSW), a licensed marriage and family therapist (LMFT), a licensed professional counselor (LPC), or a licensed psychologist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

THERE ARE EXCEPTIONS TO THE GENERAL RULE OF LEGAL CONFIDENTIALITY.
These exceptions are listed in the Colorado statutes (see section 12-43-218, C.R.S., in particular). You should be aware that, except in the case of information given to a licensed psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding. There are other exceptions that I will identify to you as the situations arise during therapy.

If you have any questions or concerns about this disclosure statement and/or would like additional information, please feel free to ask.

I have read the preceding information and understand my rights as a client/patient.

_______________________________  ________________________________        _____________________
Client Signature    Client Signature           Date

_______________________________  _____________
Guardian Signature (if minor client)  Date

_______________________________  _____________
Therapist Signature      Date
Parent/Guardian Authorization for Counseling Services for a Minor

Case #: _____________

I, ________________________ and _________________________, do hereby grant my permission for my child, _____________________________________, whose birth date is __________, to be seen for counseling purposes by a student counselor affiliated with the CU Denver Student and Community Counseling Center at the University of Colorado at Denver. I understand that the counseling sessions will be confidential and that no information or records concerning those sessions will be divulged to any person, including parents or legal guardians, without the prior consent of the individual receiving counseling services and his/her counselor or pursuant to the laws of the state of Colorado.

Parent/Guardian Signature: ____________________________  Witness Signature: ____________________________

__________________________________  _____________________________________

Date: _____/_____/____   Date: _____/_____/____

University of Colorado Denver
Student and Community Counseling Center
Child Abuse and Neglect Reporting Protocol

1. Review the facts of the case in light of the legal definition of child abuse or neglect as it appears at C.R.S. 19-3-303:

   Child abuse or neglect means an act or omission in one of the following categories:
   a. Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fractures, soft tissue swelling or death (not justifiably explained or the product of an accident.
   b. Any case in which a child is subjected to sexual assault or prostitution
   c. Any case in which a child is in need of services due to guardian’s failures to provide adequate food, clothing, shelter, medical care or supervision that a prudent parent would take

   Additional reasons for considering a report include:
   a. a runaway and/or a children who is beyond the control of parents or a danger to parents
   b. when there is a need to protect the child in the home due to:
      1. domestic violence
      2. gang activity
      3. drug activity and exposure

Note: If the incident being reported occurred while the client was a minor and/or was exposed to the abuser, however, currently she/he is an adult (over 18) there is no duty to report, unless you have strong reason to suspect that the accused abuser does have access to minor children (e.g. A step parent who is still in the home with minor children or a gymnastics coach who is still coaching minor children). The client always has the right to report past abuse. The distinction is we that we as providers do not have an obligation to report.

2. Any student counselor who suspects child abuse/neglect as defined above should first seek consultation from a Clinic supervisor

3. If a supervisor agrees a report should be made and/or a consultation call should be made to social services, the following procedures should be followed:

   a. Complete the pink information sheet entitled: Report of Abuse and/or Neglect

   b. Make the call to the appropriate county social service agency. Your supervisor will have the numbers.

   c. If a consultation, state that you are a counselor at the Center and you are calling to receive consultation about whether you need to file a report. In this situation, you may give the facts of the case and not the identifying details (name,etc)

   d. If you are reporting, you will give the intake worker all the details and identifying information you have available.
e. If you actually do make a report (vs. a consult only) you and your supervisor will sign the form and then submit it to the director for signature. After the report has been signed by all, it should be put in the client’s chart.

f. In most cases, you will inform the clients that a report needs to be made. You may or may not include them in the actual reporting. You can try to assure them that you want to continue to work with them and you do not have a choice not to report. You are mandated by law to do so. You can also let them know that the fact that they are seeking counseling is seen by social services as very positive. Of course, the hope is to maintain a therapeutic relationship, but even in cases where the clients threaten to leave counseling, our duty to report takes precedence over maintaining a therapeutic relationship.

**Note:** It is not up to us to decided whether or not abuse/or neglect is occurring. It is our duty to report our suspicions/concerns. It is the responsibility of social services to investigate assessment and make a determination.

7/26/05
Report of Abuse and/or Neglect

Date of report ________________________________________________________________  
(include day, date, exact time of initial call and any call back)

Person Reporting______________________________________________________________  
(if student, please include supervisor's name)

Agency _____________________________________  Phone __________________________

Address ______________________________________________________________________

Number called ________________________________________________________________

Name of person receiving call ___________________________________________________

Alleged abused/neglected child: Name __________________  DOB________  Gender____

Address __________________________________________

School __________________________________________

Parent/ Guardian: Name _______________________________________________________

Address __________________________________________

Phone (work) ________________  (home) ________________

Marital Status ________________  Custody ________________

Other members of household:

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<th>Relationship</th>
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Alleged Abuser:  Name ____________________________________________________________

Address __________________________________________

Relationship to child __________________________________________

University of Colorado Denver  
Student and Community Counseling Center
Was report also made by client? When? __________________________________________

Summary of information gathered by counselor regarding abuse/neglect:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Date of incident __________________________ Date of written report ________________

Date client was informed of report ______________________________________________

If not informed, why not?_______________________________________________________

Follow up:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Counselor-in-training Signature: ________________________ Date:  _________________

Clinical Supervisor’s Signature:  ________________________ Date:  _________________

Clinical Coordinator’s Signature:  ________________________ Date:  _________________
Life Pledge

Case #________________

I, ______________________________________ agree to not cause harm to myself, or to anyone else, under any circumstances (including accidental). Before I cause harm, I will speak with (DO NOT USE YOUR COUNSELOR, STUDENT COUNSELOR, OR ANYONE AT THE CENTER, BUT RATHER FAMILY MEMBERS OR A FRIEND)

_______________________________ or, ________________________________

or, ______________________________ or, ________________________________ or

a crisis line staff member, or will admit myself to a hospital where I will be safely cared for.

Client’s Signature __________________________________________ Date________________

Counselor/Student Signature ________________________________  Date _______________

Supervisor’s Signature (if applicable) _________________________  Date _______________

The client received crisis numbers as follows (at least two):

1. COMITIS Helpline: 303-343-9890
2. Denver Mental Health Center: 303-436-6266
3. University Hospital (CU-Denver students only): 303-372-6666
4. CU Health Sciences Center (after hours emergency) 303-372-6868
5. Student Health Center (Limited hours): 303-556-2525
6. PSL 303-869-1999
### Lethality Assessment

**Date:**  _____/_____/_____  
**Case #:**  ___________

1. Does the client have suicidal ideations?  
   **Yes**  **No**

2. Has the client expressed intent to commit suicide?  
   **Yes**  **No**

3. Does the client have a plan?  
   **Yes**  **No**  
   **If yes, please specify plan:**  ________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

4. Does the client have access to method/weapon?  
   **Yes**  **No**  
   **If yes, please specify:**  ________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

5. Has the client's support system decreased?  
   **Yes**  **No**

6. Does the client indicate an increase in social isolation?  
   **Yes**  **No**

7. Has the client experienced a recent trauma?  
   **Yes**  **No**

8. Does the client have a recent history of drug/alcohol abuse?  
   **Yes**  **No**

9. Does the client have a sense of hopelessness?  
   **Yes**  **No**

10. Does the client have a sense of helplessness?  
    **Yes**  **No**

11. Does the client have a history of suicide attempts?  
    **Yes**  **No**

12. Does the client have a history of psychiatric illness?  
    **Yes**  **No**

13. Is there a history of suicide in family or other support system?  
    **Yes**  **No**

14. Does the client experience chronic pain?  
    **Yes**  **No**

15. Does the client experience a chronic illness?  
    **Yes**  **No**

16. Has the client experienced a recent failure?  
    **Yes**  **No**
17. Does the client exhibit signs and symptoms of depression?  Yes  No
   If yes, please specify: _____________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

18. Has the client suffered a recent loss?  Yes  No
   If yes, please specify: _____________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

19. Has the client agreed to a life pledge?  Yes  No
20. Has the client refused to contract (life pledge)?  Yes  No

Assessment after consulting with Clinical Supervisor: (circle appropriate one)

Negligible Lethality  Low Lethality  Moderate Lethality  High Lethality

Course of Action (be specific):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Counselor Signature: ____________________________ Date: ___/___/____
Clinical Supervisor Signature: ______________________ Date: ___/___/____
Consultant Signature: ____________________________ Date: ___/___/____
Financial Agreement Form

I am a UCD or DPS student.  Yes [ ] No [ ]

- UCD students are entitled to 10 free sessions per fiscal year.
- DPS students are entitled to a one-time allotment of 10 free sessions.

Please circle your annual household income range and the number of persons supported by this income. This sliding scale will determine the fees for non UCD/DPS students and payment for UCD/DPS students after their 10 free sessions.

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<tr>
<th>Annual Household Income Range</th>
<th>1-2</th>
<th>3-4</th>
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<tbody>
<tr>
<td>$ 0 – 14,999</td>
<td>$10</td>
<td>$5</td>
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<tr>
<td>$ 15,000 – 19,999</td>
<td>$15</td>
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<tr>
<td>$ 20,000 – 24,999</td>
<td>$20</td>
<td>$15</td>
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<td>$ 25,000 – 29,999</td>
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<td>$ 30,000 – 34,999</td>
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<td>$ 40,000 – 49,999</td>
<td>$39</td>
<td>$29</td>
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<td>$ 50,000 and up</td>
<td>$40</td>
<td>$30</td>
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I understand that I am responsible for a fee of $__________ to be paid at the beginning of each session. If I fail to cancel a session in advance, I understand that I will be responsible to pay for that session prior to my next session. UCD/DPS students who fail to cancel in advance will have one free session deducted from their total.

By signing this financial agreement form, I am stating that the information provided is accurate and I have read and fully understand the policies and terms contained herein.

______________________________  ________________________________
Client/Parent/Guardian Signature  Counselor/Student Counselor Signature

______________________________  ________________________________
Client/Parent/Guardian Signature  Counselor/Student Counselor Signature

______________________________  ________________________________
Date  Date

CU Denver student’s services are funded through student registration fees, resulting in free-of-charge counseling services. CU Denver students who are enrolled in the CPCE program will be referred to another agency.
Progress Note

Client Name: ____________________________ Case Number ____________ Session # ______

Subjective (Key themes/content, client’s perspective/quotes, new developments)
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Objective (Client’s in-session behavior, demeanor, affect)
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Assessment (Improvement/progress, tentative hypotheses, treatment alliance)
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Plan (Follow-up appointment, homework/referrals given, next session topics)
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Counselor’s Name ________________________________
Counselor’s Signature __________________________ Date __________________
Supervisor’s Signature __________________________ Date __________________
<table>
<thead>
<tr>
<th>☐ Consultation</th>
<th>☐ Crisis Contact</th>
<th>☐ Termination</th>
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<tr>
<td>☐ Other (Specify): ____________________________</td>
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Client Name: ___________________________________  Case Number ____________
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Counselor Signature: ____________________________  Date: ____________

Supervisor Signature: ____________________________  Date: ____________