CASE ASSESSMENT AND TREATMENT PLAN FORMAT

1. **CLIENT NAME:**
2. **DATE OF BIRTH:**
3. **PRIMARY LANGUAGE:**
4. **REFERRED BY:**
5. **INTAKE DATE:**
6. **EVALUATED BY:**
7. **DESCRIPTION OF CLIENT:**

   Write what you observe about the client - age, sex, appearance and behaviors.
8. **PRESENTING PROBLEM:**

   Describe the problem as the client has presented it.
9. **HISTORY OF PROBLEM:**

   Describe the course of the problem, including symptoms, stressors and onset. Also include any prior treatment, including medications and referrals, and the treatment outcomes; describe the client's reactions to previous treatment or the effects on the client.
10. **MENTAL STATUS:**

    Describe the client's appearance, behavior, mood and affect, orientation, speech and cognitions, and physiological functioning. These items should not be presented in outline form but instead by descriptive paragraph(s).
11. **DEVELOPMENTAL HISTORY:** N/A - per instructor.

    The developmental history portion is applicable for a child or adolescent only, and as obtained from the parent(s) or primary caretaker.)
12. **SOCIAL HISTORY:**

    Describe the client's present living situation and her family, school, health, and social history. Also include family interactions (past and present); childhood history (including where they were born, numbers of siblings and position, relationship with parents, any history of abuse, health as a child, problems with puberty); education (including last grade completed, academic problems, behavior problems, social adjustment); interpersonal relationships (including marital/relationship history and children, sexual preference and adjustment, support network and social relationships); interests and hobbies (including leisure activities); medical history (past and present); work history (including occupation or trade, number of jobs, reasons for job changes); alcohol or drug use or abuse (past and present); military service; legal issues (past and present); religious denomination and interests (past and present); personality traits (lifelong behavior patterns).
13. **STRENGTHS AND ASSETS:**

    Describe assets that will facilitate progress and change, such as motivation, intelligence, self-discipline, willingness to utilize resources, etc.
14. **DIAGNOSIS:**

    Using the information gathered thus far, make a

    DSM-5 Diagnostic format.

    AXIS I: *(Clinical Disorders)*

    AXIS II: *(Personality Disorders or Mental Retardation)*

AXIS III: ***(General Medical Conditions relevant to management of the client's condition)***

AXIS IV: *(Psychosocial and environmental problems)*

AXIS V: ***(Use the Global Assessment of Functioning Scale)***

Include: **Current GAF _____ Highest GAF in past year _____**

15. DIAGNOSTIC RATIONALE

Present your diagnostic rationale. Include both the clinical and historical features that support your diagnosis, and include any differential diagnosis considerations. Also discuss the problems the client is having in terms of a *theoretical perspective*.

16. TREATMENT PLAN: Identify the following from a *theoretical perspective (THIS MUST BE CLEAR AND IDENTIFIABLE BY THE READER)*:

3 GOALS

Goals of Treatment 3 SHORT TERM GOALS & 1 LONG TERM -NO OBJECTIVES

1. Short-term goals: At least three clinically defined short term goals should be identified.
2. Long-term goals: At least one clinically defined long-term goal should be identified.

Mode, Frequency, and Duration

Identify the type (individual, family, group, conjoint therapy), frequency of the sessions, and the length of estimated time should be indicated.

Interventions

Identify appropriate interventions to reach each goal; identify a minimum of *three* behaviorally defined interventions with a time frame for each identified goal. Also include any possible outside referrals that may support or expand the client's progress toward attaining their goals.

12 INTERVENTION 3 SHORT TERM GOALS + LONG TERM GOAL

17. PROGNOSIS: 3 INTERVENTIONS FOR EACH GOAL SO THAT MAKES IT 12 INTERVENTIONS

Identify your projected outcome of treatment (very good, good, fair, poor, very poor), including your rationale.

18. PERSON OF THE THERAPIST

Include a summation of your impressions of the therapist in the videotape, including strengths and weaknesses exhibited during the session. Also note any ***legal or ethical*** issues that might be evident.