

The following format is to be used for case histories. For more information on individual sections see Synopsis of Psychiatry, Kaplan, Sadock, and Greeb, 7th edition, chapter 7.
Your paper should be double spaced and between 4 and 5 pages.

Case History

Date of Taped Session: Date of session to be listened to in class. Also state session XX of XX (e.g. session 7 of 8). Note the treatment setting.

Counselor Name: Your name. If session is done by two or more clinicians include the name of each, noting who lead the interview and who is doing the write-up.

Client Name: Use an alias or first name only. Please note any nicknames the client might prefer to go by.

Identifying Data: Include date of birth, age, gender, race, marital status, occupation, referral source, and whether the client came in on their own, was accompanied by someone else. (1 paragraph)

Chief Complaint: As stated by the patient in their own words, why they have come for assistance at this time. The statement should be recorded verbatim even if it doesn't make sense in the eyes of the therapist. (1 paragraph)

History of Present Illness: What is the history of the chief complaint? This information can be obtained by simply asking the question, "How did all this begin?" This section should provide a comprehensive and chronological picture of the events which led up to the current moment. Include information regarding onset of current episode and events that triggered it. Impact of the problems or chief complaint on behavior should be noted. Observations regarding secondary gains can be recorded here also. (2/3 paragraphs)

Summary of Counseling to Date: Briefly summarize your counseling process up to the current session. Include such things as the themes of material discussed in the sessions, client's level of involvement, homework assigned and completed, and how you have handled resistance. (1/2 paragraphs)

Personal History: Concisely describe relevant personal history, including family of origin dynamics. This section should be supportive of the material in the presenting problem and assessment sections. (1 page)

Below are some suggestions for areas to cover:

Early and middle childhood: Conception through age 11. Note unusual circumstances regarding conception and birth. What was the mother-child interaction? What memory themes are present? What words would the client use to describe the family atmosphere and relationships? How did the parents discipline? Favorite games or toys? What is the client's earliest memory? What was the client's early memories of school?

Late childhood: Ages 12 through 18. What was the nature of the client's relationships during this time? What activities did the client engage in? Was there anything which the client considered themselves particularly good at? (i.e. sports, musical instruments, academics) Was the client sexually active? Did the client use controlled or illegal substances? What was the client's role in their family? What does the client remember about school during this period? Where there any particular emotional or physical problems?

Adulthood:

Marital History: Describe history of each marriage, either legal or common law. Also include information regarding other significant relationships. Areas of dissatisfaction in the relationship should be included. For example issues in parenting, sexuality, housing and management of money should be mentioned. How the client perceives past failures in relationships, what went wrong and who was to blame should also be noted.

Educational History: Did the client finish high school? By degree completion or by GED? Record the number of years of post high school education with completed certificates, diplomas and/or academic degrees. If the client did not complete a particular course of education, for example stopping after completing 3 years of a 4 year degree program, note the reasons for the change.

Military History: If the client has served in the military general adjustment should be commented. Including branch of military, area of service and type of discharge.

Legal History: Include information regarding any arrests, convictions or legal judgments that the clients has been involved with. If the client has been in prison note length of sentence and what the charges were. Comment also on the client's attitude toward his or her legal history.

Medical History: What accidents, illnesses, hospitalizations, surgeries, etc. has the client experienced?

Occupational History: Record entire employment history including dates of start and finish. Include information regarding reasons for job changes, work-related conflicts, and feelings about current employment situation.

Spiritual History: What is the client's view of God? Does the client currently attend a church or religious meeting? Did the client's parents encourage or discourage religious involvement? How does the client's religious or spiritual beliefs help or hinder them? What does the client's religious beliefs say about counseling?

Social History: What is the client's history with regard to friendships, social groups, involvement in community activities, volunteerism, and community organizations.

Habits: Note habits including (but not limited to) nail biting, use of nicotine, use of alcohol, use of drugs (both prescription and non), use of caffeine, and sugar consumption. If the client has a history of substance abuse record a current assessment of use.

Past Treatment History: Record any previous treatment for mental health issues. Note both outpatient and inpatient treatment, the duration, the reason for treatment, and the client's assessment of the effectiveness.

Mental Status: Comments regarding mental status should be in this section. (1/2 paragraphs)

Below are items to consider including:

Appearance: What is the overall physical impression conveyed to the clinician? Comment on body type, weight, height, posture, poise, clothes, grooming, hair and nails. Signs of anxiety, such as sweating and perspiring, tense posture, fidgeting and wide eyes, can be included here.

Psychomotor activity: quantitative and qualitative aspects of behavior including mannerisms, tics, gestures, twitches, stereotyped behavior, echopraxia, hyperactivity, agitation, combativeness, flexibility, rigidity, gait, restlessness, wringing of hands, pacing and other physical manifestations.

Attitude: The client's attitude toward the examiner should be noted.

Mood: Note whether the client offers a description of mood or whether it is the impression of the clinician. Include statements regarding depth, intensity, duration and fluctuations.

Affect: Patient's present emotional responsiveness. Examples include: blunted, constricted, flat, expansive or within normal range. Also note whether the emotional responsiveness seemed appropriate to the subject matter.

Speech: Can be described as in both quality and quantity. Talkative, voluble, unspontaneous, rapid, slow, pressured, hesitant, emotional, dramatic, monotonous, loud, whispered, slurred, staccato or mumbled are all ways to describe client speech. Unusual characteristics such as accent or rhythms should be noted.

Perceptual disturbances: Hallucinations and illusions are noted here. Note whether they are auditory, visual, olfactory or tactile. Circumstances and content should be described. Example question: Have you ever heard voices, seen visions or had strange sensations that others did not seem to experience?

Thought: Comment on thought process (how a person thinks) and thought content. Flight of ideas, racing, tangential, circumstantial, incoherent, and thought blocking are all common descriptions of thought process. Common description of thought content includes delusions, paranoia, preoccupation, obsessions, compulsions, phobias, suicidal, ideas of reference and poverty of content.

Sensorium and Cognition: Please comment on the client's consciousness, orientation, memory, capacity to read and write, visuospatial ability, abstract thinking and fund of information by summarizing any remarkable findings from the results of the Mini-Mental Status Exam (MMSE).

Impulse control: Record whether the clients seems able to control sexual, aggressive or other impulses.

Judgment and insight: With regard to judgment can the client understand consequences to behavior? Are they able to predict what might happen and make decisions based on that information? Concerning insight comment on the client's level of self awareness, ability to recognize internal motivations and the level to which they take responsibility for their situation.

Reliability: Estimate the level to which the client appears to be a reliable source of information and their ability to report their situation accurately.

Strengths: Comments regarding client strengths can come from client's self statements and clinician's observations. Note such things are personality strengths, relational strengths, skills and job qualifications, positive family and social support, and client hopefulness.

Problems List: List, in order of assessed importance, client's problems. This information can be based on such a question as, "What are your top three problems right now?" The list recorded here may also include additions by the clinician. Add a note to each concerning whether it was a client self statement or a clinical observation. For example, 1. Depression (client) 2. Job situation (client) 3. Self-esteem (counselor). The list should not be longer than 6 items.

Client's Goals: In the client's own words record what the goals for treatment are. The question may be phrased similar to the following: "How do you think counseling could be helpful for you?"

Spiritual Assessment: Describe the client's spiritual life and the nature of their relationship to faith. Include any information on whether they find faith a help or hinderance, their understanding of God, sources of hope, areas of spirituality where they have indicated a need for growth. (1/2 paragraphs)

Assessment: Use the multiaxial system of the DSM-IV. Include assessment on each axis. All assessments should be apparent from the data included in this report.

Recommended Treatment Plan: Please note recommendations for type of treatment, duration, need for adjunct services (i.e. support groups, church or family involvement, suicide agreements, psych testing, physical evaluation, medication, etc.). Your treatment plan should indicate the theoretical orientation you are operating from and why you have chosen that orientation for this client. Your treatment plan should include goals, objectives and methods. (one-half page)

Prognosis: Record your opinion regarding the probable outcome of treatment for the current disorder/problem. Briefly (1-2 sentences) support your prognosis with known positive and/or negative factors.

Reason for Presenting Client: Comments regarding why you have chosen this particular client to present and what help you desire from the group. With regards to the help you desire make your request specific. (1 paragraph)

Transcript: The transcript section should be 20 minutes long. Pages should be divided into two columns. The left hand column should contain the text of your counseling session. The right hand column should include your explanations, assessments and evaluations of what is transpiring in the tape. *Empahsis in grading will be placed on your ability to identify such things as thinking errors, feelings, developmental issues, transference and countertransference.* Identify individuals mentioned in the tape and number the responses. Be sure to rate your responses according the system adapted from Gazada et.al.

Each transcript presentation must include at least one interaction that you feel you handled well and one interaction that you feel you did not handle well (this may require breaking up the transcript using two sections of tape). *Mark these two sections with statements in the right hand column: Handled well and Needed improvement.* In the right hand column provide an analysis of what you felt you did in each section that was helpful or not helpful.

Transcript

Individuals mentioned: Sue is the client, Tom is her husband from whom she is separated, Bob is her boyfriend.

Verbatim Transcript

Co.1: Hi

Cl.1: Hi, how are you?

Co.2: Good! Well, what would you like to talk about today?

Cl.2: I've had a really tough time this week. Tim is putting me through a really difficult time with the divorce stuff. I got really angry and went over to his work and we had this big scene and all. It was pretty disgusting.

Co.3: Sounds frustrating . . .

Cl.3: Yeah, it was. I've really had it with him and all his garbage. He is so irresponsible.

Co.4: He still isn't following through on agreements?

Cl.4: No!! (raising her voice and pounding her fist on the arm of the couch) He never does, it infuriates me so much

Co.5: How have you handled your anger over this?

Cl.5: Ok, I guess. I didn't hit him or anything.

Co.6: What about going over to his work. Was that something you felt was helpful?

Cl.6: No, I guess it wasn't, but I didn't have a choice!

Interpretive Analysis

Our sessions often start with catch up. I have worked to get the client to dig right in to the material for the session.

I deflected her question about myself and asked what she wanted to discuss. (CF2)

She has had trouble containing her behavior. It is not uncommon for her to follow her husband around and to argue in parking lots, at work etc.

Reflective statement (E2)

She likes to blame him and go on and on with this.

I should have focused on her, instead I get caught in the trap of discussing him. What follows in Cl.4 is a result. (C1)

Attempting to get back on track. (C2)

She tends to minimize her behavior.

I attempt to confront her minimization. (CF2)