CLIENT CHECK IN FORM

Client Name:____Date:_________Time:________________

Part I - Before session

Client reports:
Specific things I did to help myself (since my last session)____

____

(The following information is to be filled out by the client)

Lifestyle and Health Check-in (0 – 10)
(I rate myself right now as: 0 = low satisfaction; 10 = high satisfaction)

____ Sleep/Rest ____ Exercise ____ Diet ____ Sense of Significance/Purpose
____ Recreation ____ Self Time/Care ____ Work ____ Spiritual/God
____ Friends ____ Sense of Security ____ Intimacy ____ Freedom from addiction
____ Overall Health Have you had a fall since your last visit: ____ Yes ____ No
Where do you experience pain in body? ____

____

____ Level of Pain (0 = low, 10 = high) Tobacco Use: ____ Yes ____ No
Alcohol Use per week: ____ 0-2 ____ 3-5 ____ +5

Changes in Medication/Vitamins/Supplements: _____Yes _____No
Compliance with Rx: _____Yes _____No

Mood Check-in (0 – 10)
(0 = low amount; 10 = high amount)

_______Depressed _______ Anxious _______ Happy
_______ Violent Toward Self _______ Violent Toward Others _______ Angry

Relational Check-in (0 – 10)
(0 = low satisfaction; 10 = high satisfaction)

A significant person in my life:____

_______ Communication _______ Resolving Conflict _______ Affection
_______ Intimacy / Closeness _______ Forgiveness _______ Overall Satisfaction
Do you feel safe at home: _____Yes _____No. If No, explain: ________________________________

____

Today's Focus
Specific issue I would like to focus on today:____

____

- Stop Here -

Part II – Therapist's Notes

Part III - After session **PROGRESS NOTE**

Client: ______________________________ **Date:** __________ **Session #:** _____ **Time:** ________ ________
Start End

___**Individual** ___ **Family** ___ **Group** **People Present:**____

Location: ____**CDPCC** **Other Site:** _________________________

Subjective report of client and/or themes:

Objective Observations: (Circle) calm tense sad/tearful happy/laughing angry shaky flatten affect other:___________________
___Appropriate to situation **MSE:** __All Within Normal Limits __ Concerns ___________________________

Interventions:

- ☐ *ACT*
- ☐ *Assertiveness Training*
- ☐ *Check-in with Caretaker*
- ☐ *Client not an accurate reporter*
- ☐ *CBT/ Skill Instruction*
- ☐ *Cognitive Challenging*
- ☐ *Cognitive Refocusing*
- ☐ *Cognitive Reframing*
- ☐ *Communication Skills*
- ☐ *Compliance Issues*
- ☐ *Consultation with parents*
- ☐ *DBT*
- ☐ *Dream Work*
- ☐ *Explore/Improve Coping Patterns*
- ☐ *EMDR/bi-lateral stimula.*
- ☐ *Gathering Information to Decrease Symptoms*
- ☐ *Goal Setting and wrap–up*
- ☐ *Emotionally Focused Tx.*
- ☐ *Explore Emotions*
- ☐ *Guided Imagery*
- ☐ *Hypnosis*
- ☐ *Imago Relationship Tx*
- ☐ *Interactive Feedback*
- ☐ *Internal Family Systems*
- ☐ *Interpersonal Resolutions*
- ☐ *Mindfulness Training*
- ☐ *Preventative Services*
- ☐ *Psycho-education*
- ☐ *Relationship Patterns: Boundaries, Trust, Intimacy, Communications*
- ☐ *Relaxation/Deep Breathing/Grounding*
- ☐ *Religious Resources*
- ☐ *Review of Treatment Plan/Progress*
- ☐ *Role-Play/Behavioral Rehearsal/Modeling*
- ☐ *Self-Calming*
- ☐ *Self-care: sleep, nutrition, exercise*
- ☐ *Somatic Experiencing*
- ☐ *Structured Problem Solving*
- ☐ *Supportive Reflection*
- ☐ *Symptom Management*
- ☐ *Teaching Techniques*
- ☐ *Other* __________________

Client Response: ____

Assessment:
Suicide or homicide ideation: ___Denied ___Intent ___Plan ___Access to means:______________________

Making progress toward goals: ___Yes ___No Dx:____

Continuation of Services remains necessary to help client decrease symptoms of _____________________ _______

Treatment Plan:
Recommendation for other therapy: ___Yes ___No Type:____

Medication evaluation referral: ___Yes ___ No Continue: ___Individual ___Family ___Group

Frequency:____________ Next appointment:_____________ Goals:____

Therapist:____
Date