

Documents for Practicum and Internship to Accompany

**THE COUNSELING
PRACTICUM AND
INTERNSHIP MANUAL:
A RESOURCE FOR
GRADUATE COUNSELING
STUDENTS**

Third Edition

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CONTENTS

Old State University_Mental Health Counseling Program_Practicum and Internship Contract	4
Sample Consent to Audiotape or Videotape Permission Form	9
Weekly Practicum/Internship I Hours Log	10
Sample School Counseling Referral Form	14
Mental Status Checklist	16
Mental Status Exam (Brief Version)	19
Intake and Psychosocial Case History Interview	21
School Counseling Intake Interview	25
SOAP Progress Note	28
Client's Evaluation of Counseling Session	29
Student Counseling Session Rating Form	31
<i>Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and SOAP Client Case Notes Format</i>	34
Client Initial Intake Form	37

**Old State University
Mental Health Counseling
Program Practicum and Internship Contract**

This agreement is made on _____ by and between _____
(Date) (Practicum/Internship Site)

and the Old State University Mental Health Counseling Program. The agreement will be effective for a period from:

_____ to _____ for 100/300¹ semester clock hours for _____
(Name of Student)

PURPOSE

The purpose of this agreement is to provide a qualified graduate student with a practicum/internship experience in the field of counseling.

THE UNIVERSITY PROGRAM AGREES

To assign a university faculty liaison to facilitate communication between the university and site;

To provide weekly classroom supervision and instruction for the practicum/internship student through EDU 679, EDU 685/686/687;

To provide to the site, prior to placement of the student, the following information: profile of the previously named student and an academic calendar that shall include dates for periods during which the student will be excused from field supervision;

To notify the student that he or she must adhere to the administrative policies, rules, standards, schedules, and practices of the site;

That the faculty liaison shall be available for consultation with both site supervisors and students and shall be immediately contacted should any problem or change in relation to the student, site, or university occur; and

That the university supervisor (or practicum/internship instructor) is responsible for the assignment of a fieldwork grade. Grades are the S/U type.

¹Practicum requires a minimum of 100 clock hours. Internship requires 300 clock hours. For practicum, 40 of the 100 hours must be direct contact hours. For internship students, 120 of the 300 hours must be in direct service. Direct service is defined as individual, group, couples, or family counseling; co-counseling; clinical intakes; phone crisis counseling; team counseling and observation through a two-way mirror; running psychoeducational groups, and so forth.

THE PRACTICUM/INTERNSHIP SITE AGREES

To assign a practicum/internship supervisor who has appropriate credentials, time, and interest for training the practicum/internship student;

The clinical site must provide minimum weekly supervision for 1 hour per week;

To provide opportunities for the student to engage in a variety of counseling activities under supervision and for evaluating the student's performance (suggested counseling experience included in the "Practicum/Internship Activities" section);

To provide the student with adequate workspace, telephone, office supplies, and staff to conduct professional activities;

To provide supervisory contact that involves some examination of student work using audiovisual tapes, observation, and/or live supervision;

To provide written evaluation of the student based on criteria established by the university program; and

To not involve students in any form of billing for professional services.

Within the specified time frame, _____ will be the primary on-site practicum/internship site supervisor. The training activities (checked in the text that follows) shall be provided for the student in sufficient amounts to allow an adequate evaluation of the student's level of competence in each activity.

_____ will be the faculty liaison/supervisor with whom the student and practicum/internship site supervisor will communicate regarding progress, problems, performance evaluations, and grading.

PRACTICUM/INTERNSHIP ACTIVITIES

The following is a list of possible clinical activities for the practicum/internship student. It is not necessary that field sites have the student counselor complete all or even most of these. Check all areas that seem to apply. Additional areas of responsibility may be added in the future.

- 1. Individual Counseling/Psychotherapy** _____
 - Personal/Social Nature _____
 - Occupational/Educational Nature _____
- 2. Group Counseling/Psychotherapy** _____
 - Co-leading _____
 - Leading _____

3. Intake Interviewing

4. Couples or Family Counseling

Leading

Co-leading

5. Testing and Assessment

Administration and Interpretation

6. Report Writing

Record Keeping

Treatment Plans

7. Consultation

Referrals

Team Consultation and Case Staffing

8. Community/Psychoeducational Activities

Family Conferences

Community/Campus Outreach In-Service Presentations

In-Service Presentations

9. Career Counseling

10. Other (please specify):

Type of supervision student will receive: Individual _____ Group _____

(Needs 1 hour of formal supervision per week)

Clinical Site Supervisor: _____ Date _____

Student: _____ Date _____

Faculty Liaison: _____ Date _____

FIELD SUPERVISION

As per the Council for Accreditation of Counseling and Related Educational Programs' (CACREP) guidelines, on-site supervisors must hold a minimum of a master's degree earned in counseling or a closely related field. Closely related fields include Clinical Social Work, Counseling or Clinical Psychology, Marriage and Family Therapy, Psychiatric Nursing, and Psychiatry. On-site supervisors must have a minimum of 2-year post-master's degree experience and must be appropriately licensed in their field (LMHC, LCSW, LP, etc.).

On-site supervisors also provide individual or group supervision for 1 hour each week the practicum/internship student accrues hours. The on-site supervisor submits a written evaluation of the student's performance at the end of each semester. On-site supervisors also sign off on the student's time logs.

EVALUATION OF PRACTICUM STUDENT/INTERN'S PERFORMANCE

At the conclusion of each semester, the field supervisor will complete an evaluation of the student practicum/internship student. The evaluation form can be copied from the NU MHC manual. The site supervisor should return the evaluation to:

Coordinator, Mental Health Counseling Program

College of Education

Old State University, NY 14190

712-285-8327

ssegdoh@oldstate.edu

CONCERNS REGARDING THE STUDENT INTERN

The Field Site Supervisor

If the field supervisor has concerns regarding the student's abilities to meet the goals and objectives of the agency, the supervisor has the following options:

The field supervisor apprises the university supervisor of the concern.

The field supervisor discusses the concern with the student.

If resolution does not occur, the field supervisor should notify the university supervisor.

The university supervisor will schedule an appointment with the field supervisor and the student to facilitate the resolution.

If no resolution occurs, the field supervisor may terminate the placement.

For the student, in the event the placement is terminated, the student must find another placement and repeat the practicum or internship.

The University Supervisor

If the university supervisor has a concern regarding the student's performance: The university supervisor will inform the student that the field supervisor will be notified.

The university supervisor will seek feedback regarding the student's performance at the site.

If the concern cannot be resolved, the university supervisor will decide if the student will be placed in another setting.

If the student will receive an unsatisfactory grade, he or she will inform the student and the field supervisor that the student will need to repeat the class.

If the student does not pass the classroom or the on-site portion of the practicum/internship, the student will need to repeat the class.

Because of the nature of student practicum/internships, either the clinical site or the counseling program reserves the right to dissolve this contract should concerns arise.

Note: The agency hosting the placement, the graduate program representative, and the practicum/internship student should all keep a copy of this agreement.

Sample Consent to Audiotape or Videotape Permission Form

Sample University and the agency provide counseling opportunities for individuals, couples, families, and groups. Signing this form provides the counselor-in-training the opportunity to record your counseling session and to play the recording for the counselor's supervisor and graduate students in the Practicum/Internship class, all of whom are held to confidentiality. The recording will not be made available to anyone outside the agency or the Practicum/Internship cohort. Feel free to ask your counselor any questions about the purpose of recording and use of the recording.

Your signature indicates that you give _____
(name of your counselor-in-training) permission to be recorded (audiotaped or videotaped; circle one or both) and that you understand the following:

1. I can request the recorder be turned off at any time and may request the recording be erased.
2. The purpose of recording is for use in training and supervision. This will allow the counselor-in-training to consult with her or his supervisor(s) in an individual or group format.
3. The contents of these recorded session(s) are confidential and will not be shared outside the context of individual and group supervision.
4. The recording will be stored in a secure location and will be used only for training and supervision purposes as previously stated.
5. The recordings will be erased after they have served their purpose.

Name of Client (Please Print)

Signature

Weekly Practicum/Internship I Hours Log
300 Hours (120 Direct/180 Indirect Needed)

Dates	Direct Hours*	Clock Hours[†]	Supervisor Signature

*Direct Hours = Individual, group, couples, family counseling, co-counseling, intakes, assessment, phone crisis counseling, psychoeducational or support groups, and any direct contact with clients.

†Total Clock Hours = Any work activity that does not involve direct contact with clients.

Practicum requires a minimum of 100 clock hours, which include 40 hours of direct contact.

Internship requires 300 clock hours, which include 120 hours as direct contact.

Total Direct Hours _____

Total Clock Hours Completed _____

Student Signature

Date

On-Site Supervisor Signature

Date

On-Site Supervisor Signature

Date

Sample School Counseling Referral Form

Student name: _____

Date of birth: _____

Teacher referring: _____

Parent/guardian: _____

Home address: _____

Home phone: _____ Cell phone: _____

Please check the behaviors indicated below that serve as a reason for the referral:

- | | |
|--|---|
| <input type="checkbox"/> Unable to sit still | <input type="checkbox"/> Fails to complete homework |
| <input type="checkbox"/> Impatient | <input type="checkbox"/> Wastes time |
| <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Appears inattentive in class |
| <input type="checkbox"/> Peer conflicts | <input type="checkbox"/> Withdrawn during class |
| <input type="checkbox"/> Noncompliant with rules | <input type="checkbox"/> Appears worried/preoccupied |

Estimated level of classroom functioning: Scale of 1 to 100. Higher scores indicate greater functioning.

- | | | |
|----------------------------------|---|---|
| <input type="checkbox"/> Math | <input type="checkbox"/> Reading | <input type="checkbox"/> Language Arts |
| <input type="checkbox"/> Science | <input type="checkbox"/> Social Studies | <input type="checkbox"/> Physical Education |

Please cite any remedial services presently being rendered:

Briefly describe the issue(s) placing the student at risk. Be as specific as possible:

Briefly specify the desired behaviors you would like to see from this student in your classroom:

Teacher making this referral:

Signature

Title

Date

Mental Status Checklist

	Check	Circle	Counselor's Note
1. Posture	Normal ____	Rigid, slouches	_____
2. Grooming	Normal ____	Well-groomed Disheveled, dirty	_____
3. Dress	Appropriate ____	Ragged Too revealing	_____
4. Facial expression	Appropriate ____	Poor eye contact, stares, downcast	_____
5. Speech			
a. Pace	Normal ____	Pressured, slow	_____
b. Volume	Normal ____	Loud, low	_____
c. Tone	Normal ____	Monotone, angry, low	_____
d. Content	Normal ____	Profane, hostile, illogical	_____
e. Clarity	Normal ____	Scattered, stutters Loose associations	_____

Affect and Mood

	Check	Circle	Counselor's Note
1. Attention	Normal ____	Brief, unable to sustain attention	_____

2. Affect Normal ___ Inappropriate, flat _____

3. Mood Normal ___ Irritable, labile, depressed, _____
euphoric

Perception and Thought Content

Check if applies

Description

1. Hallucination

- a. Auditory _____
- b. Visual _____
- c. Tactile _____
- d. Taste _____
- e. Smell _____

2. Delusion

Paranoid ___ Grandeur ___ Persecutory ___ Thoughts ___

Control ___ Broadcasting ___ Other (name) _____

3. Phobias (name): _____

4. Obsessions (name): _____

5. Compulsions (name): _____

6. Suicide/homicide

Ideation: _____ Plan: _____

Timetable to carry out suicide plan: immediate, future, etc.:

Orientation: This client/student is oriented to (check all that apply):

a. Time ____

b. Place ____

c. Person ____

Judgment Good ____ Impaired ____

Memory/Ability to Concentrate

1. Immediate recall Good ____ Poor ____

2. Reversals Good ____ Poor ____

3. Serial sevens Good ____ Poor ____

Abstract Reasoning

1. Similarities Good ____ Poor ____ Bizarre ____

2. Absurdities Understands ____ Does not understand ____

3. Proverbs Normal ____ Literal ____ Concrete ____ Bizarre ____

Insight

Good ____ Fair ____ Poor ____

Mental Status Exam (Brief Version)

Now, I'm going to ask you a series of questions to test your concentration and memory. Answer to the best of your ability. Ok, any questions before we begin?

1. Orientation to time:

- a. What year is this? (1 point)
- b. What season is this? (1 point)
- c. What is the month and date? (1 point)
- d. What day of the week is it? (1 point)

(Maximum of 4 points)

2. Orientation to place:

- a. What is the name of this institution/school/agency? (1 point)
- b. What floor are we on? (1 point)
- c. What city and state are we in? (1 point)
- d. What country is this? (1 point)

(Maximum of 4 points)

3. Immediate Recall:

I am going to say three objects. After I say them I want you to repeat them. They are "ball," "flag," and "tree." Now say them. Remember them because I will ask you to repeat them later. (Interviewer: **1 point** for each; maximum of **3 points**)

4. Attention: (Serial 7s or Spelling. Choose from either of the following items but not both)

- a. Subtract 7 from 100 and continue until I tell you to stop. (Interviewer, continue until subject makes an error. **1 point** for each correct answer up to a maximum score of **5 points**)
- b. Spell the word "world" backwards. (**1 point** for each correct letter; maximum of **5 points**)

5. Delayed recall:

What are the three words I asked you to remember? (**1 point** for each; maximum of **3 points**)

6. Naming:

Show subject a pen and wristwatch and ask him or her to name them. (**1 point** for each; maximum of **2 points**)

7. Repetition:

Repeat the following sentence exactly as I say it. "No ifs, ands, or buts." (**1 point** for each word; maximum of **3 points**)

8. Stage command:

"Now I want to see how well you can follow instructions. I'm going to give you a piece of paper. Take it in your right hand, use both hands to fold it in half, and then put it on the floor." (**1 point** for each command; maximum of **3 points**)

9. Reading:

Show the subject this headline and ask her or him to read it: "The rain in Spain falls mainly on the plain." (**1 point**)

10. Copying:

Give subject a clean sheet of paper and ask her or him to draw two interlocking geometric figures (e.g., triangles, squares). If necessary draw an example for client. (**1 point**)

11. Writing:

On the same sheet of paper, ask the subject to write a complete sentence. (**1 point**)

Scoring Procedures:

Total (Maximum Score) = 30

Note: Scores of 23–30 indicate expected or “normal” functioning. Scores under 23 suggest the presence of cognitive impairment.

23–30 = no cognitive impairment

18–22 = mild cognitive impairment

0–17 = significant cognitive impairment

MSE scores may be invalid if the subject has less than a ninth-grade education, is intoxicated, or is under the influence of drugs.

Adapted from Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). “Mini-mental state.” A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research, 12*, 189–198. doi:10.1016/0022-3956(75)90026-6

Intake and Psychosocial Case History Interview

Name of Client²:

Date of Interview:

Place of Interview:

Purpose of Interview:

Name of Interviewer:

I. Introduction:

Introduce yourself, your role, explain the nature of the interview (to assist with treatment), and ask if the client has any questions.

II. Childhood:

Where were you born and raised? (Did you move? When and why did you move?) Were your parents married?

Did your mother have problems while she was pregnant with you?

Did you reach your developmental milestones such as walking, talking, potty training, on time?

With whom did you live while growing up? Who did you feel closest to?

Who in the family was most affectionate to you?

How did you get along with _____? (whoever raised you)

Who made the rules and enforced discipline?

Were the family rules clearly and consistently applied? Do you believe the rules were fair?

How often did you get punished?

How did they usually discipline you?

Were you ever spanked? (If “yes,” were there ever bruises? Did you have to see a doctor?)

Did you witness violence in the family? (verbal, physical, sexual)

Did anyone sexually abuse you or a sibling? (If “yes,” what happened? How much did this upset you? How upset are you now?)

How would you describe your personality as a child? How would peers have described you?

Did you have many friends as a child? (Any close friends? Best friends?) Were you a leader or a follower?

III. School:

At what age did you begin school?

Did you go to special education classes or regular classes? (If special classes, why?)

Were you a good student?

²Pseudonym

Did you ever repeat a grade? (If “yes,” what was the last grade you repeated?) Were you involved in school activities? (If “yes,” what types?)

What did you do after you graduated (or dropped out) of school?

Did you attend college or get advanced technical training? (If “yes,” did you graduate from college, tech school, etc.?)

Did you like school? (Explain whether “yes” or “no”)

IV. Parenthood:

Do you have any children? (If “yes,” how many? Their ages and sexes? How well do you get along with them?)

V. Friendships and Marriage:

Do you have many friends now? (Any close friends you can trust with secrets? Do your friendships tend to be long-lasting?)

Have you ever been married? (If “yes,” how many times? How would you describe your marriages? If divorced, why did you divorce? If never married, why?)

Almost all couples argue or fight at times. I’d like to know a little bit about what happens when you and your partner argue or fight. Do you or your partner ever get pushed, grabbed, or hit? Ever throw things?

If “yes”: Describe the most recent or most serious time this happened. How often does this happen? Have one of you ever had to go to the doctor after an assault?

If “no”: Did the previous situation ever happen in previous relationships? Are you ever afraid you will be physically hurt during an argument with your spouse/ partner?

VI. Relationships With Other Family Members:

Who is your immediate family? Extended family? Do you have in-laws? Grandparents? Grandchildren? Any other family?

Are your parents still alive?

If “yes”: Are you close?

How do you get along with them?

How often you visit them?

How often do you speak with them?

Have you had any recent arguments with them?

When you get angry with them, how long do you stay angry?

Do you have siblings?

If “yes”: Are you close?

How do you get along?

Have you spoken with them recently?

Have you argued with them recently?

When you argue, how long do you stay angry with them?

VII. Occupation:

Are you employed?

If “yes”: What type of work do you do?

How long have you worked there?

Do you like the work?

Why did you leave?

What is the longest job you have ever held?

If “no”: When was the last time you worked?

What kind of job was it?

What other jobs have you had?

What is the longest job you have had?

VIII. Living Situation:

Where do you live? (A house? Apartment? Condominium?)

How long have you been living there?

Where did you previously live?

Why did you move? (Have you moved often?)

Have you ever been homeless or lived in a shelter? How long were you homeless (or lived in a shelter)?

With whom do you currently live?

IX. Health:

Do you have any serious health problems? (If “yes,” describe.)

Has your illness/condition impacted your close relationships? (If “yes,” how?)

Have you been more withdrawn?

Do you argue more or less due to your health concerns?

X. Spirituality and Religious Beliefs:

Do you consider yourself a spiritual/religious person? How important are your beliefs to you?

Would you say your spiritual/religious beliefs assist you in dealing with stress, anxiety, and health concerns? (If “yes,” briefly explain how.)

XI. Satisfaction in Life:

Are you generally satisfied with your life?

If “no”: Which areas of life are you dissatisfied with?

How much are you dissatisfied?

If “yes”: What areas are you satisfied with?

How could you develop more satisfaction in your life? Would you say your life has been meaningful?

If “yes”: What accounts for the meaning in your life?

If “no”: How could you develop meaning in your life?

School Counseling Intake Interview

Date: _____

Student: _____

Age: ___ GPA: ___ Band: ___ Sports: ___ Honor Society: ___ Other Organization: ___

Reason for interview (circle): Academic, Social, Personal, Career, Other

Briefly explain reason cited in the previous line: _____

Discipline history (e.g., suspensions, fighting): _____

Student's family:

Mother's name: _____

Father's name: _____

Sibling's names and ages: _____

Parents married or living together: Yes ___ No ___

Has student had previous counseling? Yes ___ No ___. If "yes," reason for previous counseling:

Any history of physical/emotional/sexual abuse? Yes ___ No ___

What community resources is student involved with? (e.g., religious community, YMCA/YWCA, Youth

League sports)

Has this student ever been removed from his or her home? Yes ___ No ___. If so, for what reason:

Has the student been arrested? Yes ___ No ___. If "yes," what was student arrested for:

Is student currently taking medication(s): Yes ___ No ___. If “yes,” what medications:

What are the student’s strengths? _____

How does the parent/guardian describe the student’s behavior at home? (If known):

Has student acted out in socially unacceptable ways? If so, describe: _____

Does the student have friends? Yes ___ No ___

Has student made a suicide threat? Yes ___ No ___. If “yes,” how long ago?

Is the student suicidal? Yes ___ No ___. If “yes,” must activate school plan to notify parent/guardian and appropriate authorities for mental health assistance.

Does the student have a history of alcohol or drug use? Yes ___ No ___. If “yes,” what type:

_____?

Student: What are your future goals? _____

Student: What are you happiest about? _____

Student: What are you most concerned about? _____

Student: What would you most want the counselor to know? _____

Student: On a scale of 1 to 10, with 1 being *low* and 10 *high*, how optimistic do you feel regarding your life (or school performance or whatever seems appropriate depending on type of student concern). Score: _____. How could you raise that score one number in the next week? _____

Student: On a scale on 1 to 10, with 1 being *low* and 10 *high*, how effective was today's time? Score _____. How could the session improve one point next time? _____

SOAP Progress Note

S.O.A.P. stands for Subjective, Objective, Assessment, and Plan. Some people prefer DAP notes—DAP stands for Description, Analysis, and Plan.

SOAP Notes

Subjective: Subjective experience of the client as related/reported by the client. Often direct quotes from the client of his or her problems or complaints. Examples include: “I had an awful week,” “I’m feeling really depressed,” “I hate my mother,” “I can’t seem to stop worrying about my grade,” “I haven’t slept in two days.” Also, there can be statements made by the client that you summarize without using quotes.

Objective: An objective account of the client’s appearance and behaviors. May include client dress/clothing, posturing, eye contact, timeliness to session, affect, activity, speech, and so on. All the information in this section should be objective in the sense that it could be verified by observers and contains no analysis/judgment on your part. The objective section should provide a behavioral picture of the client.

Assessment: Your **theory-specific** analysis or interpretation of the client’s issues and the session. Examples include: “The client seemed to accept his anger” or “The client’s thinking was irrational in the following ways. . . .” This is your chance to hypothesize and define your conceptualization of your client’s issues.

Plan: What you plan to do in the next session. Includes homework assignments, planned exercises or techniques, and so on. When writing this section, ask yourself, “Following this theory, what is it I want to remember to do with this client?” or “What do I want to cover with the client next week?” **A plan should always be theory specific.**

Client's Evaluation of Counseling Session

Date: _____

Counselor

Client

Rate each of the statement below on a 10-point scale, where 1 = Strongly Disagree, 10 = Strongly Agree, and 5 = Neutral.

1. This session assisted you in developing a better understanding of your issue(s) and the primary problem(s).

Strongly Disagree Neutral Strongly Agree

1 2 3 4 5 6 7 8 9 10

2. This counselor seemed to have listened very well and understood my concerns.

Strongly Disagree Neutral Strongly Agree

1 2 3 4 5 6 7 8 9 10

3. Through this counseling session, I have gained a better understanding of myself.

Strongly Disagree Neutral Strongly Agree

1 2 3 4 5 6 7 8 9 10

4. This interview helped me identify new strategies to address my issues and concerns.

Strongly Disagree Neutral Strongly Agree

1 2 3 4 5 6 7 8 9 10

5. This session assisted me in identifying strengths and resources to address my concerns.

Strongly Disagree Neutral Strongly Agree

1 2 3 4 5 6 7 8 9 10

6. Because of this session, I am more inclined to change my thinking and behavior.

Strongly Disagree Neutral Strongly Agree

1 2 3 4 5 6 7 8 9 10

7. The counselor was instrumental in making today's session productive.

Strongly Disagree Agree Strongly Agree

1 2 3 4 5 6 7 8 9 10

8. I would rate today's session as: (Scale 1–10. 1 = Unhelpful, 10 = Very Helpful)

Circle the appropriate score.

1 2 3 4 5 6 7 8 9 10

9. What could you and the counselor do to raise your score by one point during the next session?

(Write your answer on the following line.)

10. What is one cognitive or behavioral change I can begin using today? (Write on following line.)

Student Counseling Session Rating Form

Date: ____/____/____

Student: _____ Evaluator: _____

Audio Recording: _____ Video Recording: _____ In-Class Role Play: _____

Brief Summary of Session Content: _____

Specific Criteria: Rating (1 = Least; 5 = Best)

1. Opening: 1 2 3 4 5

Was informed consent thorough and professional? Was confidentiality covered?

2. Rapport: 1 2 3 4 5

Did the counselor establish a good therapeutic alliance? (e.g., voice tone, appropriate eye contact, paraphrasing, summarizing)

3. Attending Skill: 1 2 3 4 5

Did the counselor use minimal encouragers and refrain from unnecessary interruptions? (Also, was counselor skilled in using therapeutic silence?)

4. Open-Ended Questioning: 1 2 3 4 5

Did the counselor make appropriate use of open-ended questions?

5. Affective Domain: 1 2 3 4 5

Did the counselor demonstrate appropriate empathy?

6. Challenging/Confrontation: 1 2 3 4 5

Did the counselor confront the client? (If necessary)

7. Solution Skills: 1 2 3 4 5

Did the counselor offer appropriate solution-seeking input?

8. Cultural Issues: 1 2 3 4 5

Did the counselor appear to understand and respect cultural issues?

(Culture would include race, ethnicity, gender, sexual orientation, religion/spirituality, etc.)

9. Goal Setting: 1 2 3 4 5

Did the counselor set effective goals for a follow-up session?

10. Closing: 1 2 3 4 5

Was closing well-orchestrated? (Or, was it abrupt?)

On the following 1 to 10 scale, how effective was the student counselor in facilitating the counseling session? (1 = lowest score, 10 = highest score)? Circle the appropriate number below:

1 2 3 4 5 6 7 8 9 10

Constructive comments for the student counselor's further development:

Signature of Evaluator

**Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and
SOAP Client Case Notes Format**

Name(s) and Age(s) of Client(s): _____

Date: ____ / ____ / ____ Code(s): _____ Session #: _____

Presenting Problem: _____

Medications:

DSM-5³:

Diagnosis: (Cite Principal *DSM-5* diagnosis and diagnostic criteria)

³Diagnosis: (Cite Principal *DSM-5* diagnosis and diagnostic criteria)

Subjective (S): _____

Objective (O): _____

Assessment (A): _____

Plan (P): _____

Counselor's Signature _____

Client Initial Intake Form

Name: _____ Date: ____/____/____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____ (H) _____ (W/C)

Identifying Information:

Age: _____ Date of Birth: ____/____/____ Place: _____

Sex: Female ____ Male ____ Height: ____ Ft. ____ In. Weight: ____ Lbs.

Marital Status: M ____ S ____ D ____ Sep. ____ Other: ____

Ethnicity: Caucasian: ____ Hispanic/Latino: ____ Asian: ____ African American: ____

American Indian: ____ Multiethnic: ____

Spouse's/Partner's Name: _____ Age: _____

Occupation: _____ Employer: _____

Name(s)/Age(s) of Children (If applicable)

Referral Source: _____

Address of Referral Source: _____

Treatment History:

Are you currently taking medication? Yes: ____ No: ____

If "yes," name of medication(s): _____

Provider of medication(s): _____

Have you received previous psychiatric/psychological treatment?

Yes: ____ No: ____

If "yes," name the psychiatric treatment provider: _____

Dates of counseling/psychiatric treatment: _____

Has any close relative ever had psychiatric treatment or been committed to a psychiatric hospital?

Yes: ____ No: ____ If "yes," please explain:

What factor(s) led you to seek counseling services? _____

Symptoms: _____

Family History:

Father's name: _____ Living: ____ Deceased: ____

Occupation: _____

Mother's name: _____ Living: ____ Deceased: ____

Occupation: _____

Brother(s)/Sister(s):

Name: _____ Age: ____ Living: ____ Deceased: ____

Name: _____ Age: ____ Living: ____ Deceased: ____

Name: _____ Age: ____ Living: ____ Deceased: ____

Educational History:

(Name of institution, location, dates attended, degree)

High School: _____

College/University: _____

Technical School: _____

Graduate/Professional: _____

Military Information: (If applicable)

Branch of Military: _____

Dates of Active Service/Reserve Commitment: _____

Were you in a combat zone? Yes: _____ No: _____

Did you receive any medical treatment as a result of injuries? Yes: _____ No: _____

If “yes,” what injuries were you treated for? _____
