Form 3.1a: Parental Release Form: Secondary School Counseling

[School district name] offers short-term individual counseling and group counseling to students as the need arises. Parents/guardians or school staff may refer students for counseling, or students may request counseling. These counseling services are provided by [Counselor’s name], the school counselor, or [Intern’s name], the counseling intern. Should it be determined that more extensive services are needed, it is the parent’s responsibility, with the assistance of the counselor, to arrange outside counseling or psychiatric services.

School counseling services are short-term services aimed to enhance the education and socialization of students within the school community. Trust is a cornerstone of the relationship between the counselor and student. Information shared by the student will be kept confidential except in certain situations in which ethical responsibility limits confidentiality. You will be notified if:

1. The student reveals information about hurting himself/herself or someone else.
2. The student or someone else may be in physical danger.
3. A court order is received directing disclosure of information.

We encourage you to contact us whenever you have a question, input, or concern.

The counseling intern is an advanced-level master's degree student in the Department of Counseling and Psychology at [University name]. The University requires that the counseling sessions conducted by the counseling intern be audio/video-recorded for confidential supervision purposes. Personal identifying details will be deleted, and the tape will be reviewed by the supervisor and peer members of the supervision group to review the counseling practice of the intern. The tape will be destroyed after the supervision review. Supervision requires that ethical standards regarding confidentiality be followed.

Student’s name ____________________________

By signing this form, I give permission for my child to receive counseling services during the 20__ school year. I understand that anything my child shares is confidential except in the above-mentioned cases.

Parent/guardian ____________________________ Date ______________________

I do _____ do not _____ give permission for the taping of sessions for confidential supervision purposes.
Form 3.1b: Elementary School Counseling Permission Form

Short Form

We, the parents of __________________________________________________________, acknowledge and approve of our child being seen by the elementary school counselor or counselor intern. The counselor may engage our child in any counseling services deemed appropriate in encouraging positive educational and social development.

We understand that the intern is an advanced-level graduate student in the Department of Counseling and Psychology at _________________ University and will audio/videotape counseling sessions for supervision purposes. The tape will be reviewed by the University supervisor and peer group members of the supervision seminar to evaluate the intern’s counseling practice. The tape will be erased after supervision. Supervision requires following confidentiality standards established in the professional code of ethics.

_____________________________________
Parent signature

_____________________________________
Date

OR

We, the parents of __________________________________________________________, acknowledge but do not give our permission for our child to be seen by the elementary school counselor or counseling intern to receive counseling services. We decline the offer of services at this time but reserve the opportunity to reconsider services at a later date.

_____________________________________
Parent signature

_____________________________________
Date
Form 3.2: Client Permission to Record Counseling Session for Supervision Purposes

I, ________________________, give my permission for the counseling intern, ______________ to audio/videotape my counseling sessions __________________________ (fill in date or inclusive dates if over a period of time). [If client is under 18, change wording to “tape the counseling sessions with my child” and fill in child’s name.] I understand that the counseling intern at _______________Agency is an advanced-level master’s degree student in the Department of Counseling and Psychology at _______________ University. The University requires that the counseling sessions conducted by the counseling intern be audio/video-recorded for confidential supervision purposes. Personal identifying details will be deleted, and the tape will be reviewed by the supervisor and peer members of the supervision group to review the counseling practice of the intern. The tape will be destroyed after the supervision review. Supervision requires that ethical standards regarding confidentiality be followed.

____________________________________  Name of agency supervisor

____________________________________  Name of university supervisor

____________________________________  Client’s signature  Date

____________________________________  Parent/guardian signature
Form 3.3: Initial Intake Form

Name ________________________________________________________________ Date ________________
Address ___________________________ City ___________________ State __________ Zip _____________
Telephone (home) _____________________ (work) ____________________ (cell) ____________________
Counselor’s name ____________________________________________________ Date ________________

Identifying Information

Age ________________________ Date of birth _____ /_____ /______ Place _________________________
Sex: Male _______ Female _______ Height _______ ft. _______ in. Weight _____________ lbs.
Race: White _______ Black _______ Asian _______ Hispanic _______ Other _______________________
Marital status: M ______________ S ____________ D ____________ W ____________ Sep _____________
If married, spouse’s name ____________________________________________________ Age ___________
Occupation (client) ___________________________________ Employer ____________________________
Occupation (spouse)__________________________________ Employer ____________________________
Referral source: Self___________________________________ Other _______________________________
Name of referral source _____________________________________________________________________
Address of referral source __________________________________________________________________

Treatment History (General)

Are you currently taking medication? Yes ________ No ________
If yes, name(s) of the medication(s) __________________________________________________________
Dosage of medication(s) ____________________________________________________________________
Provider of medication(s) ___________________________________________________________________
Have you received previous psychiatric treatment? Yes _____ No _____
If yes, name provider _______________________________________________________________________
Dates of service __________________________________ Location _________________________________
Reason for termination of treatment _________________________________________________________
Presenting problem or condition (current) ___________________________________________________
Presenting factors (contributors) ____________________________________________________________
Symptoms (describe) _______________________________________________________________________
___________________________________________________________________________________________
Acute ______________________________________ Chronic ______________________________________
Family History (General)

Father’s name _____________________________________ Age _____ Living _____ Deceased _____
Occupation ___________________________________________ Full-time _____ Part-time _____
Mother’s name _____________________________________ Age _____ Living _____ Deceased _____
Occupation ___________________________________________ Full-time _____ Part-time _____

Brother(s)/sister(s)
Name ___________________________________________ Age _____ Living _____ Deceased _____
Name ___________________________________________ Age _____ Living _____ Deceased _____
Name ___________________________________________ Age _____ Living _____ Deceased _____

Educational History (General)

<table>
<thead>
<tr>
<th>Name of institution</th>
<th>Location</th>
<th>Dates</th>
<th>Degree</th>
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<td>Secondary __________</td>
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<td>Trade _______________</td>
<td>__________</td>
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<td>Graduate ____________</td>
<td>__________</td>
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</tbody>
</table>

Employment History (General)

<table>
<thead>
<tr>
<th>Title/description</th>
<th>From when to when</th>
<th>Full- or part-time</th>
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</table>
Form 3.4: Psychosocial History

Directions: Practicum/internship students should review/complete this form prior to the initiation of therapy and after completion of the Initial Intake Form.

I. Identifying Information

Name _______________________________________________________ Age _______________________
Address _____________________________________________ Date of birth _______________________
Phone _________________ Cell phone _________________ Marital status _______________________

II. Presenting Problem/Complaint

Nature of complaint? ___________________________________________________________________
________________________________________________________________________________________
When did the problem begin? (date of onset) _____________________________________________
How often does it occur? (be specific) ____________________________________________________
How does it affect your daily functioning? ________________________________________________
________________________________________________________________________________________
Are there events, situations, and person(s) that precipitate it? _____________________________
________________________________________________________________________________________

Symptoms:
Acute (describe) _______________________________________________________________________
________________________________________________________________________________________
Chronic (describe) _____________________________________________________________________
________________________________________________________________________________________
Previous treatment (list by whom, outcome, and reason(s) for termination of treatment) ______
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Medical:
Physician’s name _______________________________________________________________________
Treatment dates from ______________________ to ______________________
Describe _______________________________________________________________________________
________________________________________________________________________________________

Psychiatric:
Therapist’s name _______________________________________________________________________
Treatment dates from ______________________ to ______________________
Substance use ____________________________

III. Developmental History

Pregnancy ____________________________

Delivery ____________________________

Infancy (developmental milestones) ____________________________

Middle childhood (developmental milestones) ____________________________

Young adulthood (developmental milestones) ____________________________

IV. Family History

Where were you born and raised? ____________________________

What culture/ethnic group do you identify with? ____________________________

What is your primary language? ____________________________

Parent (names, ages, occupations) ____________________________

Were your parents married? Yes _______ No _______

Do they remain married? Yes _______ No _______

If divorced, how were you affected by it? ____________________________

Who was primarily responsible for your upbringing? ____________________________

Describe the relationship between your parents ____________________________

Describe your relationship with your parents ____________________________

Do you feel supported by your family? Explain ____________________________

Do you feel loved in your family? Explain ____________________________

Describe how love was expressed in your family ____________________________

Who was the disciplinarian in your family? ____________________________
How was discipline handled? ____________________________________________________________
__________________________________________________________________________________
Were you physically, verbally, or emotionally abused in any way? __________________________
__________________________________________________________________________________
Describe your best memory ______________________________________________________________
__________________________________________________________________________________
Describe your worst memory ____________________________________________________________
__________________________________________________________________________________

V. Educational/Occupational History

Education (highest grade achieved) ______________________________________________________
Describe your school performance ________________________________________________________
__________________________________________________________________________________
Did you take any special classes? Explain _________________________________________________
__________________________________________________________________________________
Did you have any special needs? _________________________________________________________
__________________________________________________________________________________
Do you have adequate reading skills? Yes ______ No ______
Do you have adequate math skills? Yes ______ No ______

Occupational

Have you served in the military? _________________________________________________________
When and where did you serve? _________________________________________________________
What was your rank? _________________________________________________________________
Describe your duties _________________________________________________________________
Usual occupation _________________________________________________________________
Present status: Employed? ______ Unemployed? ______ Full time ______ Part time ______
Job satisfaction: Good ______ Fair ______ Poor ______
Estimate the number of jobs that you have held __________________________________________
Longest continued employments (dates) _________________________________________________
Reason(s) for leaving? Explain _________________________________________________________
__________________________________________________________________________________
What impact does your present concern have on your employment?
None ______ Terminated ______ Absenteeism ______ Tardiness ______ Laid off ______
Poor work performance ______ Conflict with fellow workers ______
Conflict with employer ______
VI. Health History

Childhood diseases (list) ________________________________________________________________
________________________________________________________________________________________

Surgeries? ______________________________________________________________________________
________________________________________________________________________________________

Current health (describe) ________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Family health (grandparents, parents, children) ___________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Current medications (prescribed and over the counter). List ________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Do you have any chronic medical problems? _____________________________________________
________________________________________________________________________________________

Do you have any bio-medical problems requiring medical monitoring? ______________________
________________________________________________________________________________________

VII. Relationship History

Single _________ Married _________ Separated _________ Divorced _________ Widowed _________
Common law _________ Years married? _________
Number of children (names and ages) ____________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Problems, stressors in the relationship? Explain ___________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Your perception of sexual relationship (attitudes/behavior) _________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Have you ever been physically or emotionally abused in the relationship? ______________________
________________________________________________________________________________________

VIII. Additional Information

Information that has not been covered that you feel is an important consideration in your
 treatment (explain, be specific) __________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
Form 3.5: Case Notes

These case notes are confidential and must be kept in a secure place under the control of the counselor.

Counselor's name __________________________  Agency/school __________________________

CLIENT IDENTIFYING DATA

Client's ID ______________________________________________ Age ____________  Sex __________

Date of session ___________________________________________  Session number _________________

Taping: Audio ____________________________________  Video ___________________________________

Presenting/current concern

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Key issues addressed

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Summary of the session

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Diagnostic impression(s) and interventions

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Client progress/setbacks (current internal/external dynamics that support or inhibit change)

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
Plan


Counselor's comments


Supervisor's comments


Date __________  Counselor's signature ________________________________

Date __________  Supervisor's signature ________________________________
Form 3.6: Weekly Schedule/Practicum Log

<table>
<thead>
<tr>
<th>Day of week</th>
<th>Location</th>
<th>Time</th>
<th>Practicum activity</th>
<th>Comment</th>
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</thead>
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</tbody>
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Student counselor name _____________________________________________

Week beginning ___________________________ Ending ___________________________

Total hours of direct service __________________ Indirect service __________________

Site supervisor signature ___________________________ Date ___________________________
Form 3.7: Monthly Practicum Log

Directions:

1. Record the dates of each week at the site where indicated.
2. Record the total number of hours per week for each activity under the appropriate column.
3. Total the number of hours for the week at the bottom of the week's column.
4. At the end of the month, total the hours spent in each activity by adding the hours across each activity; indicate the total in the monthly totals column.
5. Get the supervisor's signature. Keep this in your file to be submitted to the university internship coordinator at the completion of the internship.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Week 1 From: To:</th>
<th>Week 2 From: To:</th>
<th>Week 3 From: To:</th>
<th>Week 4 From: To:</th>
<th>Monthly Totals</th>
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</thead>
<tbody>
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<td>Intake interview*</td>
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<tr>
<td>Individual counseling*</td>
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<tr>
<td>Group counseling*</td>
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<td>Consulting/intervention*</td>
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<td>Psychoeducation/guidance*</td>
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<td>Community work</td>
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<td>Career counseling*</td>
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<td>Testing/assessment</td>
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<tr>
<td>Individual supervision</td>
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<td>Other</td>
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<td>Weekly totals</td>
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<tr>
<td>Total direct contact*</td>
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</table>

*Indicates direct contact

Intern's name _______________________________

Supervisor's signature and date _______________________________