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Welcome to the Center!

You are now ready to embark on the final phase of the Marriage and Family Therapy program at Chapman University. The fact that you are here in the Center signifies that you have been reviewed by the faculty and deemed ready to see clients in a real clinic setting.

Although you are still a graduate student, officially you are a Marriage and Family Therapist Trainee, as defined by the Board of Behavioral Sciences (BBS).

This is an important fact to know: As an MFT Trainee, you are bound by the same laws and legal and ethical guidelines as a licensed MFT.

The Frances Smith Center for Individual and Family Therapy is a real outpatient mental health clinic that offers services to members of the community. While you are here to develop your skills as a clinician and learn the many facets of the field, you have entered the professional world and are expected to conduct yourself according to BBS standards.

This manual is to provide you with a resource to consult on the multitude of issues that you will encounter as an MFT Trainee. While it is not an exhaustive and complete resource, it has been written as an introduction and should be helpful to you in providing a place to start.

One of the most important things you need to remember:

WE DO NOT EXPECT YOU TO KNOW ALL THE ANSWERS

BUT WE DO EXPECT YOU TO ASK THE QUESTIONS!
TRAINEE INFORMATION AND FORMS

The following forms are reviewed and signed by all Center trainees prior to or during orientation to the Center: (See Addendum for copies of actual forms)

MFT TRAINEE INFORMATION: This form provides not only basic information on the trainee (e.g., address, telephone numbers), but also bilingual skills, previous counseling experience, special training, and other information that is utilized when assigning clients.

OATH OF CONFIDENTIALITY: Required for any student that is permitted to be in the Center.

CHILD ABUSE AND NEGLECT REPORTING LAW: Information pertinent to all mandated reporters.

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDERS: Information pertinent to all mandated reporters.

DRESS CODE: Form outlines the Center's dress code and rationale.

PRACTICUM REQUIREMENTS FOR MFT TRAINEES: This form provides a comprehensive list of requirements for Center trainees.

SOCIAL MEDIA: Information related to social media and legal/ethical considerations and Center policy.

PHOTOGRAPHIC CONSENT AND RELEASE: University form related to consent to be photographed and photos posted related to Center activities and other University-related activities.

FERPA CONSENT TO RELEASE STUDENT INFORMATION: Information regarding what information will be released and to whom (e.g., report of face-to-face hours to clinical supervisors).

PROTECTING CHILDREN FROM SEXUAL MISCONDUCT TRAINING: Online training module through Chapman Risk Management regarding protecting minors from sexual misconduct. Module and certificate to be done and submitted to Department Assistant prior to starting in the clinic as a trainee.

CONCERNS, COMPLAINTS & GRIEVANCES

The Marriage and Family Therapy Program at Chapman University strives to have a safe environment in the classroom, clinic, amongst students, faculty, and staff. Chapman University expects students to adhere to the Student Code of Conduct.

The Student Code of Conduct reviews Chapman University’s stance and policy on how to address issue such as discrimination, bullying, and harassment. If these incidents have occurred, information on filing a grievance can be found on the Chapman University website under Sexual Misconduct, Sex-Based/Gender Discrimination, and Title IX.
From time to time students may have concerns, complaints, or grievances while enrolled in the program. The Marriage and Family Therapy Program at Chapman University uses the following definitions in accordance with COAMFTE standards to define what is a concern, complaint, or a grievance.

A concern is defined as informal and relates to minor issues that can be solved between individuals such as student/instructor or student/program director and are usually communicated to the program director or faculty verbally or through informal written communication (i.e., email). Examples may include concerns about course scheduling, timeliness of faculty feedback, etc. When a concern is brought to the attention of the MFT program, the MFT Program Director, MFT Program Manager, Frances Smith Center Clinic Director or other MFT faculty member or staff, whomever is most appropriate to respond, will give a response within ten business days. The program does not generally keep formal records of student concerns.

A student complaint is outlined as being communicated to the program in writing regarding issues that have significant negative impact on students' learning experiences. Examples may include a grade appeal. Complaints generally require completion of the Graduate Petition form to bring about resolution, and records regarding their resolution are kept on file in the MFT program for ten years. Further information regarding Chapman University’s petition and appeal process can be found in the Graduate Catalog under Academic Policies and Procedures.

According to COAMFTE, a student grievance refers to formal complaints filed with the program and/or the university through a formal grievance channel. They refer to issues that may violate students' rights. Examples include sexual harassment and discrimination. Information regarding filing a formal grievance can be found on the Chapman University Sexual Misconduct, Sex-Based/Gender Discrimination, and Title IX webpage. Records regarding the resolution of grievances are generally kept on file for a period of ten years.

If a student is dissatisfied with any aspect of a class (e.g. content, lectures, presentations, assignments, exams, grades), students are encouraged to discuss the issue openly and constructively with the instructor. If a student is unable to resolve the issue with the instructor, the student should contact the Program Director, Dr. Naveen Jonathan. If the issue is still unresolved, students will be referred to the Crean College Dean, Dr. Janeen Hill.

If a student has a concern regarding advising and Plan of Study, the contact person would be the Program Manager, Cassidy Manton. If the concern is about the Frances Smith Center, Susan Jester, the Clinic Director, is the point of contact. For any concerns that are related to an external traineeship, concerns/feedback on the program, accreditation, or a grievance, please follow up with Dr. Naveen Jonathan.
CENTER REQUIREMENTS

HOURS, EVALUATION & GRADING

In order to meet the requirements of the 12-month practicum in the Frances L. Smith Center for Individual and Family Therapy, you must complete the following:

1. **HOURS**: You will obtain a minimum of 300 "direct service" hours in the Center of which 120 hours must be relational. Overall, to complete within one year the 300 hours you are required, you will need to complete a minimum of 6 hours per week of therapy and client centered advocacy hours combined.

2. You must participate in a minimum of 2 collaborations during your year of practicum.

3. Complete all file documentation per Center guidelines.

4. All Monthly Activity Reports and BBS log sheets are to be completed and signed by your supervisor on a monthly basis.

5. At the end of each semester the Hour Verification Form are to be completed and signed by your supervisor.

6. **TRaineE EVALUATION**: Each trainee will be evaluated by their individual supervisor at the end of each semester. Your evaluations will remain part of your Center file. You may keep a copy of your evaluations for your records as well.

   a. The trainee will be evaluated in a series of categories on a scale of 0 to 3 as follows:

   b. 0 = Inadequate Information
   c. 1 = Deficient
   d. 2 = Below Expectation
   e. 3 = Meet Expectation
   f. 3 = Exceeds Expectation
   g. 3 = Exceptional Skills

7. **Grading**: Each trainee will be graded by their group supervisor at the end of each semester. Grading criteria is carefully outlined on the MFT 694 syllabus distributed by the group supervisor at the beginning of each semester.

NON-NEGOTIABLES

NO client files, individual documents pertaining to a client, testing or session recordings may be photographed, copied or taken out of the Center in any format at any time. Violation of this rule may cause dismissal from the program. You may work on paperwork in an open counseling room or the Observation Room (Room 112-A) by using unoccupied counter space. Note, however, that live supervision has precedence.

NO eating or smoking in the Center office, therapy rooms, and Observation Room (Room 112-A). **ABSOLUTELY NO LIQUIDS ARE TO BE IN THE OBSERVATION ROOM (Room 112-A).**

NO ONE other than members of the Center staff, Center trainees, supervisors, and MFT 573 students are permitted in the Center office (Room 123) or Observation Room (Room 112-A). Use courteous assertion with anyone who is not authorized to be in these areas.
DRESS CODE

All trainees will be required to follow the Center’s dress code as part of their professional training. Understanding the clinical significance of one’s appearance and the non-verbal messages it conveys is extremely important. Trainees are expected to make the transition from “student” to “professional.”

All trainees will be required to review and sign the Dress Code form during orientation.

SOCIAL MEDIA

Social media outlets have exploded in recent years (e.g., Facebook, Twitter, Linked In, etc.). As a result, the concept of professional and therapeutic boundaries has become even more important to understand and adhere to. The following questions are posed:

- Where do you draw the line with clients?
- Where does a client’s and therapist’s privacy end or begin on such sites?
- Public vs. private information
- Who owns the material posted?
- How does this affect one’s professional reputation?

Much of this will be litigated in courts and as rulings are made, they will be incorporated into Law and Ethics classes; however, no one wants to be a test case for such a ruling. Therefore, the following rules apply not only during the year you are here at the Center, but also after you leave, as it applies to the Center:

1. You may NEVER “friend” a client – EVER. Even after you graduate from Chapman and the Center, you may not ever “friend” a client that you had here at the Center.

2. Review any and all Social Media privacy controls to implement the highest level of privacy on your site. You will soon see that this is a small world, and the “six degrees of separation” concept really applies.

3. You may not use Social Media to write or comment on anything related to your caseload, supervision, or anything that might be seen and misconstrued by a client, either current or former. Examples of this include:
   - “Had the worst clients today! All they did was argue!”
   - “Mary the therapist at the Clinic is horrible.”
   - “I can’t believe my supervisor even has a job!”
   - “Hope my 6pm client no-shows!”

   There are many other examples, but the above gives an idea of the type of inappropriate comments.

4. In addition to comments, you may not take pictures that may include any client-related items or that conveys any sense of casualness or lack of professionalism. For example, a picture of another trainee joking around with a stack of client files next to him/her; or someone sitting at a computer with the computer screen showing an intake summary.
THE CENTER – GENERAL DESCRIPTION

The Frances Smith Center for Individual and Family Therapy was established in 1969 as a training clinic for the MFT program, as well as a community service. Our Center is one of a few low cost/sliding scale clinics in Orange County. It is staffed by MFT trainees supervised by licensed faculty in compliance with State and BBS requirements.

The Center is located in:

Crean Hall
501 W. Palm Ave.
Orange, CA 92868
(714) 997-6746

Note, however, that the mailing address remains the University’s address: Frances Smith Center for Individual and Family Therapy, 1 University Dr., Orange, CA 92866.

DIRECTIONS

From the North: Take the 5 Fwy South to the 22 Fwy East to Glassell exit. Turn left onto Glassell and continue to the Old Towne circle, picking up Glassell on the other side. Go the second stop sign (Palm) and make a left onto Palm. Go down 4 blocks past the railroad tracks (the streets you will cross will be Olive, Lemon, Cypress, and then the tracks). The Center is in Crean Hall, which is the brick building on the right side through the black entrance doors.

From the South: Take the 5 Fwy North to the 55 Fwy North to the 22 Fwy West. Exit on Glassell/Grand, and make a right on Glassell. Continue past the Old Towne circle, picking up Glassell on the other side. Go the second stop sign (Palm) and make a left onto Palm. Go down 4 blocks past the railroad tracks (the streets you will cross will be Olive, Lemon, Cypress, and then the tracks). The Center is in Crean Hall, which is the brick building on the right side through the black entrance doors.

PARKING

Clients can park either on the street on Palm (note the color of the curb), or in the City parking lot across the street from Crean Hall. Handicapped parking is available in the lot locate behind Crean Hall.

HOURS

Center hours are generally Monday through Friday from 9:00 am to 9:00 pm, (subject to change depending upon availability of on-site licensed staff), and Saturday 9:00 am to 5:00 pm.

GENERAL OFFICE PROCEDURES

Center Safety: In case of a potentially life-threatening emergency, dial 9-1-1 from any Center telephone and contact the nearest supervisor. Dialing 9-1-1 from a campus telephone will automatically connect you with Campus Safety. Such emergencies include: A client who is in imminent danger of self-harm, a client who has made an imminent threat to others, a burglary or break-in to the Center, etc.

In situations where the Clinic Director is not on-site during working hours (e.g., vacation, illness, off-site meetings), information will be posted directing you to the nearest supervisor who is providing coverage during her absence.
OPENING THE CENTER

1. If you are the first one in the Center in the morning, open the key box to obtain the keys and unlock the 3 file cabinets.

2. Turn on the lights in the lobby and all counseling rooms.

3. Turn on the video monitors in the Observation Room (Room 112-A) and adjust lights to the appropriate setting to insure one-way windows are operating correctly.

CLOSING THE CENTER:

If you are the last person to leave at night or on Saturday, please complete the Daily Checklist to Close-Up the Center form to ensure that the Center has been secured.

STAFF LOUNGE

Room 131 is available to you for food and breaks. You are welcome to use the appliances (refrigerator, microwave, coffee maker, etc.). Along with that privilege goes your responsibility to keep the room clean. Specifically this means:

1. No dirty dishes in the sink area. Wash your dishes and place in the draining rack.
2. Do not collect leftovers in the refrigerator.
3. Only eat or drink what belongs to you!
CENTER SAFETY PROCEDURES

The following procedures are outlined to address specific types of safety concerns and/or emergencies that may occur during the course of your practicum. Please read carefully and ask questions.

CLIENT RELATED SAFETY PROCEDURES

In order to insure safety for both our trainees and clients, each of the counseling rooms has a telephone installed capable of dialing out. Posted on the telephone is a list of numbers in case of emergency. These numbers include: Public Safety, the County of Orange C.A.T. team, as well as extensions for the Clinic Director and the Clinic Assistant.

During your Center orientation, emergency procedures for contacting the C.A.T. team will be reviewed for a client who may be suicidal or danger to self or others. In addition, there are two telephones in the back observation room (Room 112A) with the same dialing out capabilities. Please review policies regarding specific guidelines to assess suicidal clients and potentially violent clients.

Public Safety: (714) 997-6763

Public Safety is located at 418 N. Glassell. They are available 24 hours a day, 7 days a week. If you are leaving Crean Hall and would like an escort to your car, call Public Safety and they will send an officer to accompany you.

In addition, if your card key malfunctions and does not allow entrance to Crean Hall, contact Public Safety and they will send an officer to provide access.

ON-SITE SUPERVISORS

Posted each semester is a chart that identifies the location of any Center supervisor during normal Center hours. Should you have a client emergency that requires consultation with a supervisor, please refer to the chart to locate a supervisor on-site. If one is not available, telephones numbers of all Center clinical staff is posted in the Center, and you have been given a complete telephone list as well.

OTHER EMERGENCIES

In case of a power outage, an emergency lantern is in each counseling room on the book shelf. Please help to safely escort all individuals out of the Center and out through the front door of Crean Hall.
SUPERVISION

Supervision is one of the most valuable components of your experience here in the Center. Your supervision requirements for the Center are:

Group:  2 hours per week
Individual:  1 hour per week

Effective 1/1/95, BBS requirements for supervision of MFT trainees are: 1 hour of individual OR 2 hours of group for every 5 client hours.

Center requirements for supervision are that you are to attend all scheduled supervision weekly, regardless of client hours. Simply speaking, you are expected to attend both supervisions, even if you did not see any clients during the week. See MFT 694 syllabus for more detailed information.

GROUP SUPERVISION (MFT 694)

Group supervision meets weekly for 2 hours. It is considered a practicum class and you will receive a grade for this 4-unit class.

GRADING

Grades will be assigned based on the timeliness and quality of each assignment.

The point distribution for semesters 1 and 2 will be as follows:

<table>
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<th>Assignments</th>
<th>Fall semester</th>
<th>Spring semester</th>
<th>Summer semester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal case present.</td>
<td>10 pts.</td>
<td>10 pts.</td>
<td>10 pts.</td>
</tr>
<tr>
<td>Live observation</td>
<td>10 pts.</td>
<td>10 pts.</td>
<td>10 pts.</td>
</tr>
<tr>
<td>Formal case present.</td>
<td>45 pts.</td>
<td>45 pts.</td>
<td>45 pts.</td>
</tr>
<tr>
<td>Theory of Change</td>
<td>15 pts.</td>
<td>15 pts.</td>
<td>15 pts.</td>
</tr>
<tr>
<td>Attendance/Participation</td>
<td>150 pts.</td>
<td>150 pts.</td>
<td>120 pts.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>20 pts.</td>
<td>20 pts.</td>
<td>20 pts.</td>
</tr>
<tr>
<td>MAXIMUM TOTALS</td>
<td>250 pts.</td>
<td>250 pts.</td>
<td>220 pts.</td>
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The point distribution for semester 3 will be as follows:

<table>
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<tr>
<th>Assignments</th>
<th>Fall semester</th>
<th>Spring semester</th>
<th>Summer semester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Captstone Project</td>
<td>120 pts.</td>
<td>120 pts.</td>
<td>120 pts.</td>
</tr>
<tr>
<td>Attendance/Participation</td>
<td>150 pts.</td>
<td>150 pts.</td>
<td>120 pts.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>20 pts.</td>
<td>20 pts.</td>
<td>20 pts.</td>
</tr>
<tr>
<td>MAXIMUM TOTALS</td>
<td>325 pts.</td>
<td>325 pts.</td>
<td>285 pts.</td>
</tr>
</tbody>
</table>
INDIVIDUAL SUPERVISION
Your individual supervisor will be your primary supervisor for all cases, and you will meet with your individual supervisor every week. Your BBS log sheet will be signed by your individual supervisor as well.

SUPERVISION CONTRACT
During the first individual supervision, you will review and collaborate on the "Individual Supervision Contract" with your individual supervisor, who is considered your primary supervisor and will sign off on all BBS forms, file documentation, etc. You will then be provided with a copy of this form after it has been completed and signed by both you and your supervisor. This contract outlines specific information regarding supervision.

In addition to information outlined in the Individual Supervision Contract, please note the following:

Supervision begins the first week of the semester. For new trainees, you are expected to attend supervision, even though you may not have any client assignments.

If you must miss supervision (individual or group) due to illness or emergency, you are expected to notify your supervisor accordingly. You will be given a staff telephone list which will list your supervisor’s telephone numbers.

If your supervision time is pre-empted by a holiday (e.g., Labor Day is on a Monday and your group supervision is on Monday), your supervisor will advise you when the supervision has been rescheduled.

Your individual supervisor will sign the BBS form, “Responsibility Statement for Supervisor of MFT Intern or Trainee” within the first week of the semester. Please retain this form in the hanging file for all BBS paperwork. (Page *)

SUPERVISOR EVALUATION FOR MFT TRAINEE EXPERIENCE
You will be evaluated by your individual supervisor at the end of each semester. Your evaluation will encompass the following areas:

- Conceptual Skills
- Perceptual Skills
- Professional Skills
- Evaluation Skills
- Executive Skills
- Theory

Your evaluation will be on a scale of 0 to 3, with narrative comments.

0 = Inadequate information
1 = Deficient information
2 = Below Expectation
3 = Meets Expectation
3 = Exceeds Expectation
3 = Exceptional Skills

Your evaluations will remain part of your Center file. You may keep a copy of your evaluations for your records as well.

STUDENT EVALUATION OF CLINICAL SUPERVISOR
In addition to evaluation by your Supervisor, you will be asked to complete an evaluation on your Supervisor and supervision experience every semester.
CAPSTONE PROJECT

As part of the graduation requirements, MFT students are required to complete a Capstone Project in their final semester in the MFT Program.

The Capstone Project will include three parts, A). a theory of change paper (completed in MFT 566) B). a comprehensive written case report and C). an oral case presentation, which includes a videotape demonstrating specific interventions (completed by final semester in MFT 694).

A. Theory of Change Paper (to be completed in MFT 566)

B. Comprehensive Written Case Report

During their training at the Frances Smith Center the students will select a relational case (couple/family) based on which they will write a Comprehensive Written Case Report as part of the Capstone Project. The Comprehensive Written Case Report will be submitted to the group supervisor during the final semester at the Frances Smith Center along with the final version of the Theory of Change Paper. The student will be expected to prepare a three-generation genogram of the individual/couple/family they are writing the case report on. The case report will be based on the following format:

1. **Identifying information and clinical data** (age, gender, ethnicity, family composition, occupation and/or school status, relationship status, SES, treatment history, clinical symptoms, presenting problems, medications, history of mental illness or family dysfunction, significant medical problems, why client is seeking treatment).

2. **Systemic assessment and clinical assessment**, utilizing the genogram (include significant family patterns and events, chemical dependency, others living in the home, medical problems, intergenerational issues). If treating a couple, include information about their relationship history.

3. **DSM-5 Diagnosis**, listed by number and providing rationale for client’s diagnosis, including symptoms and client’s report of symptoms. If appropriate, provide a differential process. Do not forget to diagnose each client you are treating in the treatment unit.

4. **Theoretical model of treatment**, used to conceptualize the case, develop the treatment plan and intervene.

5. **Case Conceptualization**, which is a tentative explanation of the ways in which relational patterns are operating to keep a family from, and move a family toward optimum functioning. Case conceptualizations are dynamic and should evolve over time as the case progresses. Your case conceptualization should be derived from on-going clinical assessment that is informed by systems theory in general and MFT clinical theories and models in particular.

6. **Treatment objectives/goals**, develop a complete treatment plan and prioritize treatment goals based on assessment, diagnosis, and chosen theoretical model. Treatment plan should be consistent with a theoretical model and should be broken down into a beginning, middle and closing phase.

7. **Brief summary of how change could be anticipated** to occur for this individual/couple/family (within the theoretical model)
8. **Description of the role of the therapist** within the theoretical model

9. **Specific interventions** and techniques that have been used and will be used. Therapeutic interventions should be presented consistent with the chosen theory. This section should include a discussion of client’s motivation for treatment, specific interventions implemented, including rationale, expected outcome, and potential barriers to treatment. The interventions should be informed by research and the case report should demonstrate that through citations. If relevant, describe how crisis issues were managed. Also discuss the implementation and management of safety plans if applicable.

10. An assessment of possible **transference and counter transference considerations**

11. A discussion of possible **ethical/legal** considerations and how they would be addressed. Include a discussion of the identification and management of any legal/ethical obligations and mandates that apply specifically to the case.

12. Discuss any **diversity** considerations and how they may impact treatment, including:

   - **Cultural identity** (ethnic/cultural reference). For immigrants and ethnic minorities, note the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use and preference (including multilingualism).
   - **Cultural factors related to psychosocial environment and levels of functioning**: Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.
   - **Cultural elements of the relationship between the individual and the clinician**: Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual’s first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).
   - **Overall cultural assessment for diagnosis and care**: The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

13. **Case management** considerations (consents and initial structuring of treatment, who attends sessions, managing family secrets, missed appointments, crisis management, referrals, termination, etc.)

14. **Client-centered advocacy (CCA)** (any adjunctive services that would be important to meeting treatment goals including referrals, telephone conversations, and other CCA-related activities)

15. **Evaluation of the therapeutic process to date**, including an assessment of the therapeutic relationship

The grading guidelines for the Comprehensive Written Case Report and the Comprehensive Written Case Report Evaluation Form can be found in the Appendix.
C. Oral Case Presentation

During the time allocated for group supervision all graduating students will make an Oral Case Presentation around midterm time in their final semester in the Frances Smith Center as part of their Capstone Project. The Oral Case Presentation will follow the same format as the Comprehensive Written Case Report. The presentation should not take more than 60 minutes following which 20 minutes will be for questions from the supervisor and 20 minutes for discussion which will make a total of 1 hour 40 minutes. The Oral Case Presentation should be accompanied by a Power Point which should be submitted to the group supervisor 1 week prior to the Oral Case Presentation. The Oral Case Presentation should include four videotape clips from sessions with the client(s). The clips should be from sessions from different phases of treatment including early, middle and current phase.

The same grading guidelines will be used for both the Comprehensive Written Case Report and the Oral Case Presentation (pp. **). Some questions that the supervisor could ask after the Oral Case Presentation can be found on pages 92-125.

Grading for the Capstone Project

In order to overall pass the Capstone Project the student must pass all three components of the Capstone Project which include the:
A). Theory of Change Paper
B). Comprehensive Written Case Report and
C). Oral Case Presentation

Passing the Capstone Project

In order to pass the Capstone Project the student should get a “meets or exceeds expectations” on all the sections of the Theory of Change Paper. The student should also get a “meets or exceeds expectations” on all sections of the Comprehensive Written Case Report as well as the Oral Case Presentation.

Passing the Capstone Project with Recommendations

If the student gets a “below expectations” on any section of the Theory of Change Paper, Comprehensive Written Case Report or the Oral Case Presentation the student will pass with recommendations. The recommendation will be provided by the group supervisor and the student will have to show proof of completion before graduation.

Failing the Capstone Project

If the student gets a “deficient” on any section of the Theory of Change Paper, Comprehensive Written Case Report or the Oral Case Presentation the student will fail the Capstone Project. The group supervisor will provide the student with stipulations in consultation with the Clinic Director and the Program Director. The student will have to show proof of completion of the stipulations in order to graduate. The Final Evaluation Form for the Capstone Project can be found in the Appendix.
TELEPHONES, VOICEMAIL, AND ANSWERING SERVICE

The primary numbers you should know for the Center are as follows:

(714) 997-6746  Main Clinic #
(714) 744-7698  Voicemail # to be given to clients
(714) 516-5545  Voicemail # to call to retrieve messages
(714) 667-0467 #2686 La Bell Exchange (answering service)

General Information: The Center’s main number is 714-997-6746. Please keep the main lines open for incoming calls. Please do not place personal long-distance calls from a Center phone. Utilize your cell phone instead.

To call out, please dial “9” to obtain an outside line.

STAFF TELEPHONE LIST

You will receive a copy of the staff telephone list at the beginning of each semester. This list includes telephone numbers for all supervisors and Center personnel, as well as emergency numbers.

VERY IMPORTANT

If your home, work, or cell number changes, you must notify the Department Assistant immediately. The reason for this is the Center must have current numbers at all times in case of a client emergency. In addition, this information is provided to the answering service and Campus Safety. Failure to notify the Center of a telephone number change may result in not being able to locate you when there is a client emergency.

VOICEMAIL

Once a client has been assigned to you, you should advise the client to use the voicemail number to leave messages. The number is (714) 744-7698, plus your 2-digit extension.

You will be assigned a 2-digit extension number that will then access your own personal voicemail box. This extension number may change each semester as the voicemail is organized in alphabetical order by the trainee’s last name. You will be notified of any changes in your extension number in advance so that you can notify your clients.

You are expected to check your voicemail at least 2 times daily Monday through Friday, and once a day on Saturday and Sunday and all holidays. It is suggested that you also check it prior to coming to the Center for a session, as you may have a late cancellation.

All messages from clients or client-related messages are to be documented in the client’s file. See the section on “Documentation” regarding the protocol.

You will be given a form entitled “Voice Mail Instructions” that outlines how to access your voicemail, pick up messages, delete messages, and record your voicemail greeting.

Should you have any problems with your voicemail box, please report this immediately to the Clinic Director or the Department Assistant.

NOTE: YOU MAY NOT GIVE OUT YOUR CELL NUMBER TO CLIENTS – EVER.
ANSWERING SERVICE

La Bell Exchange is the answering service for the Center. Their telephone number is (714) 667-0467, account no. 2686.

The purpose of the answering service is to have an operator that can take emergency calls from clients for the purpose of reaching the trainee. The operator has a list of the trainee’s home, work, and cell numbers and will contact all numbers in order to reach the trainee, leaving a message to call the service if there is no answer. In the event that the trainee cannot be reached within the hour, the Clinic Director will be contacted.

Please note: the answering service personnel are not trained as “hot line” counselors – they are switchboard operators only. They will be courteous and professional but are not able to talk with clients therapeutically. Please advise your clients of this.

NOTE: If you go out of town and another trainee is on call for you, you must call the answering service and notify them of the dates you will be absent and who are on call for you. (See the section entitled “Vacation Policy/Buddy System” for further instructions.)

If your telephone number changes (home, work, or cell), please notify the answering service immediately, as well as the Department Assistant.
VACATION POLICY / BUDDY SYSTEM/CENTER HOLIDAYS

VACATIONS NOTIFICATION FORM

If the trainee plans to take vacation time during the course of practicum, he/she must complete the “Vacation Notification Form” and have it signed by their individual supervisor, then submit it to the Clinic Director prior to the first day of vacation.

HOLIDAYS:

The Center is open year-round but closed for certain holidays. You will be notified of the holidays in advance to remind your clients. The holidays are:

- Martin Luther King holiday
- Spring Break (one week)
- Week between Spring and Summer semester
- Memorial Day (Monday)
- July 4th holiday
- Week between Summer and Fall semester
- Labor Day (Monday)
- Thanksgiving week
- Christmas/New Year (approx. last 2 weeks of December)

BUDDY SYSTEM:

Any time a trainee will be out of town and not picking up messages, he/she must designate a colleague who will be on call for their clients.

The name and extension of the “buddy” must be given to all clients as the person to call in case of an emergency.

Please follow the instructions listed on the “Vacation Notification Form.”

For any absence that is more than a weekend, the trainee should change their voicemail to advise clients of their absence, who is on call, and how to reach the on-call therapist. See the instructions listed on the Voice Mail Instructions (see Appendix)


**CENTER HOLIDAYS**

**THE CENTER WILL BE CLOSED ON THE FOLLOWING DAYS**

<table>
<thead>
<tr>
<th>Holiday</th>
<th>Date Observed*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martin Luther King Holiday</td>
<td>third Monday of January</td>
</tr>
<tr>
<td>Spring Break</td>
<td>third or fourth week of March</td>
</tr>
<tr>
<td>Graduation</td>
<td>third or fourth week of May</td>
</tr>
<tr>
<td>Spring/Summer Break</td>
<td>end of May</td>
</tr>
<tr>
<td>Memorial Day</td>
<td>last Monday of May</td>
</tr>
<tr>
<td>Independence Day</td>
<td>fourth of July</td>
</tr>
<tr>
<td>Summer/Fall Break</td>
<td>mid August</td>
</tr>
<tr>
<td>Labor Day</td>
<td>first Monday of September</td>
</tr>
<tr>
<td>Thanksgiving Break</td>
<td>week of Thanksgiving</td>
</tr>
<tr>
<td>Christmas Holiday Break</td>
<td>break occurs between Fall and Interterm</td>
</tr>
</tbody>
</table>

*Please check the most recent schedule for exact dates*
BBS FORMS

BOARD OF BEHAVIORAL SCIENCES (BBS)

According to current BBS regulations, you become a Marriage and Family Therapist Trainee (MFT Trainee) when you have completed 12 units in a qualified Master's program.

BBS regulations change periodically. While we will make every effort to keep you informed of current regulations, you are responsible for keeping current on changes in the law. To insure accurate information, contact the BBS directly – do not rely on information provided by other trainees.

The BBS address, telephone number, and website are:

Board of Behavioral Sciences  
1625 North Market Blvd., Suite S200  
Sacramento, CA 95834  
(916) 574-7830  
www.bbs.ca.gov

RESPONSIBILITY STATEMENT FOR SUPERVISORS OF A MARRIAGE AND FAMILY THERAPIST TRAINEE OR INTERN: You must have this form signed during the first or second week of the semester by every individual supervisor you have in the Center. Retain this form for your records – you will submit it when you are applying for licensure.

WEEKLY SUMMARY OF HOURS OF EXPERIENCE: This form is what we call the BBS log sheet. It should be completed on a weekly basis and signed by your individual supervisor. You will retain the originals and keep them for your records.

MARRIAGE AND FAMILY THERAPIST EXPERIENCE VERIFICATION: You will complete this form after each semester and collaboration. This form will include all Center hours and will be signed by your supervisor verifying your hours of experience in the Center. Retain this form and submit it when you are applying for licensure.
SIGNING UP FOR A COUNSELING ROOM

The room schedules are posted on a weekly basis and updated daily for the following week. Please read the following directions carefully as failure to follow the format can result in your not having a room for your client. If you are not in the Center when scheduling, you can have the Department Assistant, or another trainee write in the information for you.

If a room is available on the day and time you need it, write in your last name and the client’s initials in the appropriate box. If this is to be a permanent, weekly appointment, **WRITE THE INFORMATION IN RED INK**. This signifies that the room will be assigned to you on a weekly basis in the computer.

If your need for the room is temporary (an emergency session or the first session and you’re not sure what the regular appointment time will be), **WRITE THE INFORMATION IN PENCIL**. This signifies you need the room for that week only.

If a client cancels their appointment for that week, or does not show up for their appointment, **HIGHLIGHT YOUR NAME AND THE CLIENT’S INITIALS ON THE SCHEDULE**. This signifies that the room is available for that week only, but remains assigned to you by the computer.

If a client terminates or transfers to another day and time, please “**X**” OUT THE INFORMATION IN THE BOX ON THE SCHEDULE IN RED INK. This signifies that the room is now available to others for ongoing scheduling.

If a client calls to cancel or reschedule, and you are not in the Center at the time you pick up the message, you can leave a message for the Department Assistant (714-532-6084) or email. This helps to insure that all rooms are utilized to their full potential.

**REMEMBER:**

**RED INK = PERMANENT (EVERY WEEK)**

**PENCIL = TEMPORARY (THIS WEEK ONLY)**

**HIGHLIGHT = TEMPORARY OPENING (THIS WEEK ONLY)**
THE FIRST SESSION

Please read the following information carefully prior to your first session.

When scheduling the initial appointment, ask your client to arrive 30 minutes early in order to complete paperwork. If directions are needed, general directions are outlined in Section 2 of this manual.

If you are unable to be here 30 minutes before your client, you should assemble the appropriate paperwork on a clipboard with a post-it note listing the client’s name, date and time of session, and your name and place the clipboard near the front window.

Forms to be completed by a new client in the lobby:

**Adults**
- General Intake Information (2-sided)
- Fee Agreement OR Fee Reduction
- OQ-45

**Child/Adelescent**
- Child/Adelescent Intake Information (4 pages)
- Fee Agreement OR Fee Reduction
- Child Behavioral Checklist (CBCL-II)
- Child Custody Consent (if applicable)
- Acknowledgement Re: Outside Evals (if applicable)

After the client has returned the forms to you, review the forms quickly to ensure that they are completed and signed. If the client has not answered a question, or dated and signed the form, return it immediately with instructions to do so.

When you take the client to the counseling room, take the clipboard with the completed forms, along with 2 copies of the **AGREEMENT FOR SERVICE/INFORMED CONSENT** form with the client’s name, your name, and your extension number filled in on the form. In addition, take either blank paper or a blank **Initial Intake** form in order to take notes during the intake session.

Once in the counseling room, you must first review with the client the **Agreement for Service/Informed Consent form**. Give the client a copy and have the client date and sign the other form, which you will retain for the client’s file. You must also sign the form after the client’s has signed it. Please make a note of any questions or concerns that your client expresses about the informed consent – this should be noted in the session note when you document that informed consent was obtained. Your client will also complete and sign the research agreement.

A sample script immediately follows which details information that should be included during your discussion of informed consent and the research agreement.

After the session has ended, you will complete a session note (can be either handwritten or typed), as well as a Mental Status form. Then put the entire file, including the **Agreement for Service/Informed Consent form**, the **Fee Agreement** form, the **Mental Status** form, and any other paperwork, in the Clinic Director’s hanging file. She will review it, the file will be labeled, and it will be returned to you.

General information about the session:

(a) Watch the clock! The session is 50 minutes – not 60 minutes.

(b) Schedule sessions on the hour only (e.g., clients cannot be seen at 4:30, 5:15, etc.)
(c) Do not conduct therapy in the hallway, either going to or leaving the counseling room. This is unprofessional and a disregard for the client's privacy.

(d) Use the “In Session” sign when you are in a room with a client, and be sure slide it over to “Available” when you are finished.

Documentation to be completed after the initial session:

1. Process note, including that informed consent was reviewed and obtained, and any questions or concerns the client may have expressed about it.

2. Mental Status form (if a couple, one is completed for each member)

3. Intake Summary: Write up your initial diagnostic impressions and use the second session to provide feedback to the client and clarify any diagnostic questions that remain.

4. Psychosocial History: Begin to transfer information to your typed intake summary and use the second session if needed to obtain any remaining information.

5. Log onto the Session and Fee Record form the date, CPT code, and client payment.
SCRIPT TO REVIEW INFORMED CONSENT

This last form I need for you to take a few minutes and read over carefully. It is called the “Information for Clients” and it outlines many issues that you, the client, need to be aware of with respect to your therapy here at the Center. I’ll have you sign one form, and this one (hand the client a copy) is for you to keep.

As you have already been told, I am a Marriage and Family Therapist Trainee. I will be down here in the Center until __________, 20__, seeing clients under the supervision of licensed faculty. My current supervisor is ______________, and is listed here on this form.

I also want you to know the limits of confidentiality. Under the therapist-client privilege, what we talk about is confidential, but there are 3 limits to confidentiality that I want to make sure you are aware of. By law, I must break confidentiality if I feel that you are at risk of harming yourself and I need to take steps to keep you safe. I also must break confidentiality if you are at risk of harming someone else. Third, as I am a mandated reporter, I am required to report child abuse and neglect and dependent adult/elder abuse or neglect.

Because this is a training clinic, at times we do record sessions and live observations as part of the training here at the Center. The training is for the purposes of my training as an MFT trainee. Recording and live observation of my sessions is for supervision and it is an important part of my experience in the MFT program.

When I record our sessions, the recording and any observation are considered confidential and held to the same standards as any other communication in therapy. After being reviewed by my supervisor, all recordings are destroyed in a confidential manner consistent with mental health standards.

[IF THE CLIENT REFUSES, THEN STATE THE FOLLOWING]

As this is a training clinic, it is an integral part of the training that I am able to record my sessions and have my work observed. Therefore, if you do not consent to my recording the session or being observed, then what I can do is give you referrals to other low cost clinics in the area that do not record as part of their training. Let’s go ahead up to the front window, and I will give you these referral numbers.

Please read this form carefully and take your time. If you have any questions, please ask me as you go along.

You'll see there are several categories:

Information on our staff and services
Information regarding confidentiality
Records and recordkeeping
Risks and benefits of therapy
The assessment period of therapy
Information regarding sessions and appointments, along with the 24-hour cancellation policy
Payment and fees
The counseling agreement

Again, please take your time and ask any questions that you may have.
REVIEW OF RESEARCH AGREEMENT WITH CLIENTS

In addition to the Informed Consent, this form is to let you know that as a training facility, the Frances Smith Center will now be participating in research projects conducted by Chapman students and faculty that are deemed to advance the understanding of relationships and human functioning. There are two different methods by which information will be gathered in the Center.

1. You may be asked if you would like to actually participate in a research project. As such, you will be told what kind of research it is, what your participation would require, and there will be separate consent forms that you will be asked to sign. Please know that **YOUR TREATMENT AT THE FRANCES SMITH CENTER WILL NOT BE AFFECTED BY YOUR DECISION WHETHER OR NOT TO PARTICIPATE.**

OR

2. Your Center records may be utilized for research purposes. As such, your anonymity will be protected as the information gathered will only be reported as group information. If you decide you do not want your records to be used for research, the Clinic Director/ Associate Director will insure that your records are not used. Again, **YOUR TREATMENT AT THE FRANCES SMITH CENTER WILL NOT BE AFFECTED BY YOUR DECISION WHETHER OR NOT TO PARTICIPATE.**

Please read over the form, check the box that reflects your decision re use of your records, then date and sign the form.

[NOTE: YOU MUST MAKE SURE THAT THE CLIENT HAS CHOSEN ONE OF THE BOXES. DO NOT RETURN THE FORM DATED AND SIGNED WITHOUT ONE OF THE BOXES BEING CHECKED.]

**************************************************************************

NOTE: What if the client asks questions such as, “What kind of information in my record”? Here are some examples:

- How many sessions you completed at the Frances Smith Center
- Comparison of OQ-45 scores at beginning and end of therapy
- How many clients dropped out of therapy
FEES / RECEIPTS / SESSION AND FEE RECORD

Center policy is that payment is due at the time of the session. Do not allow a client to accrue a balance. If your client states that they cannot pay for their session, have forgotten their checkbook, etc., advise them of the Center’s policy and that payment in full will be due at the next session.

Clients are advised of their fee at the time of the telephone intake. If they have requested a fee reduction, this will be noted on the form as well. (See instructions regarding a fee reduction.)

Center policy is that the client must give at least 24 hours’ notice or they will be charged for the session. This policy is to be enforced with clients. If you do not, you are almost guaranteed many no-show and last minute cancellations, for which you cannot count the hours.

Payment can be made in cash or check only – the Center cannot take payment by credit card. In addition, we do not have the ability to give change. Therefore, if a client pays in cash, they must have the exact amount.

A receipt must be filled out and attached to all payments. If the client has not brought payment with them, a receipt is still filled out with a “$0.00” in the payment section.

You are assigned a receipt book while in the Center. The original receipt is given to the client; the 2nd copy is paper-clipped to the payment (or alone if no payment) and put into the cash box; the 3rd copy remains in the receipt book. See the example below as to format:

1. Date of payment
2. Client’s initials (do not write the name for confidentiality reasons)
3. Amount of payment – not the amount due but the amount attached to receipt
4. The CPT code (a list of codes is located next to the lobby window, as well as at the bottom of the Session and Fee Record form. (Page *)
5. Trainee’s name
6. If the client has a balance/payment greater than the session fee
7. Amount of payment
8. Balance remaining (or credit)
9. If paid by cash
10. If paid by check or money order

SESSION AND FEE RECORD:

The fee record includes not only what the client has paid, but also the record of client sessions, including cancellations, no-shows, and re-scheduling. At the bottom of the form are codes to be used for recording this information:

C = Client cancelled with at least 24 hours’ notice
L/C = Client cancelled with less than 24 hours’ notice
N/S = Client did not show up for session and gave no notice
P = Payment only (client not seen – merely made payment)

These codes are to be recorded on the Session and Fee Record form in the section entitled “CPT Code.” If the client had a late cancellation or no show, the session fee should be recorded as a balance to be collected at the next session.

The Session and Fee Record form must be kept current and accurately reflect the client’s activity and balance. Random file check will be made and this information must be current.
If your client begins to accrue a balance, please speak with your Supervisor or the Clinic Director regarding how to handle the issue. **REMEMBER: MONEY IS ALWAYS A CLINICAL ISSUE!**

**CLIENT FEE INFORMATION**

Each client must sign the **Fee Agreement** form. This form will be completed and attached to the Initial Intake form when it is assigned to you.

After the client has dated and signed the form, you must also sign it as the MFT Trainee.

After the first session, put the **Agreement for Service/Informed Consent** form and the **Fee Agreement** form into the file with your process note and any other paperwork. Then place the file in the Clinic Director’s hanging file.

**REQUEST FOR FEE REDUCTION**

Occasionally one of your clients will indicate that due to special circumstances, they are unable to pay the assessed fee and request a fee reduction. Or, during the Initial Intake, the caller will request a fee reduction. Please follow the guidelines listed below:

Have the client complete the information listed in the box in the center of the **Fee Reduction** form in its entirety, then date and sign it. (Page 137)

The standard fee reduction is 25% of the assessed fee. A copy of the **Client Fee Range** form is included in this section. If the client is requesting a fee reduction greater than 25%, please consult with the Clinic Director for direction.

After the client has completed and signed the form, you must also sign it as the MFT Trainee. Follow the same procedures as listed for the **Fee Agreement** form above.

After the form has been signed, it should then be filed in the client’s file on the left side underneath the **Session and Fee Record**.

**IMPORTANT: PLEASE NOTE THE FOLLOWING:**

Your client must pay for each session – they are not to accrue a balance. If they have received a fee reduction, the fee reduction becomes void if they do not keep their balance current.

The late cancellation policy applies also to a fee reduction.

Remember that the fee reduction has an expiration date – you are responsible for monitoring it and re-evaluating the fee with the client prior to its expiration.
“3.3 Marriage and family therapists maintain patient records, whether written, taped, computerized, or stored in any other medium, consistent with sound clinical practice.”

*Part I: Ethical Standards for Marriage and Family Therapists (1997) California Association of Marriage and Family Therapists*

Documentation is an important component of this profession. Thorough and accurate record keeping is vital, not only to providing effective therapy, but also to insure that legal and ethical guidelines are maintained to minimize legal liability.

The following description of documentation requirements has been developed to insure that you as an MFT trainee follow sound legal and ethical principles of the Marriage and Family Therapist profession.

Some of the forms you will be required to complete may be unique to the Center; however, all paperwork and forms have been designed to help you to develop the skills you will need as a competent and ethical therapist.

Please review the following sections very carefully. It is impossible to cover every possible situation that may occur; therefore, consult with your Supervisor or the Clinic Director if you have any questions.

**WHAT IS DOCUMENTED IN THE CLIENT’S FILE?**

Basically, all contact between the MFT trainee, the Supervisor, and the client must be documented in the client’s file. This includes the following:

Every time you call your client.

Every time your client calls you.

Any calls made to or received from other professionals (psychiatrist, teacher, physician, etc.)

Process notes for every session.

All supervision, either directly in supervision or on the telephone between supervision sessions.

Every “no show” or rescheduled session.

Every payment made (or not made).

All correspondence made to a client or received from a client. (This includes if you receive a Christmas card, thank you card, etc.)

Every action taken outside of a session in response to a legal and ethical issue (e.g., call to a supervisor regarding concerns you have about a suicidal client).

Any calls made to comply with legal and ethical mandates (e.g., Child Protective Services, Adult Protective Services, police department, or the target of a Tarasoff warning).
NOTE: This list is not complete – consult with your Supervisor or Clinic Director if there is a question regarding documentation.

Your process notes are considered medical documents, and must be written in such a manner that would stand up in a court proceeding (e.g., in liability cases or in ethics complaints). A general rule of thumb to keep in mind regarding documentation is: If it isn’t written down, it didn’t happen.” There is no substitute for a timely, thoughtful, and complete chart record that demonstrates clear and well-written assessment and treatment notes.

**CLIENT FORMS**

Acknowledgment of Center Policy re: Outside Evaluations

Adult General Intake Information

Agreement for Service/Informed Consent

Authorization for Multiple Treatment Modalities

Authorization to Release Information or Records

Child/Adolescent Intake Form

Child Custody Consent

Client Contact Log

Fee Agreement

Fee Reduction

File Checklist

Intake Assessment Form

Intake Summary

Mental Status

Research Agreement

Release of Information

Session and Fee Record

Session Notes

Supervision Notes

Treatment Summary
<table>
<thead>
<tr>
<th>FORM:</th>
<th>ACKNOWLEDGMENT OF CENTER POLICY RE: OUTSIDE EVALUATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE:</td>
<td>Confirm that a client has been informed about the Center’s policy re: evaluations</td>
</tr>
<tr>
<td>WHO:</td>
<td>Any client that presents with issues that suggest a client may be seeking services that require documentation of evaluation (e.g., custody, disability, etc.)</td>
</tr>
<tr>
<td>WHEN:</td>
<td>At the beginning of the initial session</td>
</tr>
</tbody>
</table>

At times, a client will present with issues that suggest he/she may request documentation to support a court case, claim for services, etc. The Clinic Director reviews all telephone intakes prior to assignment, and will contact a potential client if the information presented suggests that this may become an issue. The client is then advised that because the Center is a training clinic, we are unable to provide documentation in the role of either an expert, or suggesting that the therapist possesses a level of expertise in a particular area. In cases where documentation will be required, the Clinic Director will provide appropriate referrals so that the client is able to obtain the level of services needed.

Common examples of this include:

1. child custody evaluation;
2. any court evaluation;
3. social services evaluation;
4. probation or parole evaluation;
5. workers compensation/disability evaluation; or
6. any other type of evaluation which may require testifying in court.

The purpose of the form is to confirm that this information has been provided to the client (or to the parent and/or guardian). The signed form then becomes part of the client’s file.
FORM: ADULT GENERAL INTAKE INFORMATION

PURPOSE: To gather client information, including medical history and previous psychiatric history

WHO: Every adult client

WHEN: Prior to initial session

This is a 2-sided form that is to be completed by the client, dated, and signed. For couples, each individual should complete a separate form. It is very important that you review this form for information that will assist in your assessment, as well as to insure that the client has completed the form in its entirety and signed it.

In particular, please note the following areas:

Family History: Provides information about family history of depression, suicide, and substance abuse. This information should be addressed during the session and additional narrative obtained.

Medical History: This section may provide Axis III information. In addition, you should follow up with the client how the medical issue(s) may impact the presenting complaints.

Prior Psychotherapy: If a client has received therapy in the past, you should ask questions as part of your assessment. For example, “Why did you seek therapy at that time? Was it successful? If not, why not? What was helpful? What was not helpful?”

In addition, if the client lists therapy within the last 10 years, you should attempt to obtain a signed Release of Information form to obtain records. NOTE: If the client refuses, explore the reason, document the client’s refusal, and discuss this with your Supervisor.

If the client is currently under the care of a psychiatrist, you must have the client sign a Release of Information form to enable contact between the two of you. Often the psychiatrist can be helpful regarding diagnostic information. In addition, it is often helpful to have the signed release on file as a precaution in case the client’s condition deteriorates.

If the client has been hospitalized for psychiatric reasons, you must obtain a signed Release of Information form for the hospital records. Typically, these records can provide very useful information, including a psychosocial history.

NOTE: NEVER SEND A RELEASE OF INFORMATION HOME WITH A CLIENT. INSTEAD, GET AS MUCH INFORMATION AS YOU CAN, HAVE THE CLIENT DATE AND SIGN THE FORM, THEN CALL THE CLIENT AT HOME AND GET THE MISSING INFORMATION.
FORM: AGREEMENT FOR SERVICE / INFORMED CONSENT

PURPOSE: Informed consent and disclosure of Clinic policies

WHO: Every client age 12 and older, and parent/guardian of a minor

WHEN: At the beginning of the initial session

You will provide informed consent and obtain signature(s) with all clients prior to the commencement of therapy by having all clients age 12 and above, and/or the parent/guardian of a minor sign the Agreement for Service/Informed Consent form. For parents who are married or divorced with joint custody, you must obtain written consent from both parents. If one parent denies his or her consent for treatment, then you cannot treat the minor child.

Informed consent includes the following: you are an unlicensed MFT trainee, the name of your supervisor, and that you will be discussing his/her/their case with your supervisor as part of supervision.

When you take the client to the counseling room, take the clipboard with the completed forms, along with 2 copies of the Agreement for Service/Informed Consent form with the client’s name, your name, and your extension number filled in on the form. In addition, take either blank paper or the Psychosocial History form in order to take notes during the intake session.

Once in the counseling room, you must first review with the client the Agreement for Service/Informed Consent form. Give the client one of the copies, and have the client date and sign the other form, which you will retain for the client’s file. You must also sign the form after the client’s has signed it. Please make a note of any questions or concerns that your client expresses about the informed consent – this should be noted in the session note when you document that informed consent was obtained.

A sample script immediately follows which details information that should be included during your discussion of informed consent.

After the session has ended, place the Agreement for Service/Informed Consent form in the client’s file and place in the Clinic Director’s hanging file for review. After review, the file will be labeled and returned to you.

NOTE: As you will typically have a change in Supervisor each semester, you must get a new Agreement for Service/Informed Consent form signed if there is a change in Supervisor for all ongoing clients in your caseload. Rather than having to review informed consent in its entirety, merely explain that your Supervisor has changed and the new form includes their name, license, and how to reach them. Give the client a copy of the new Agreement for Service/Informed Consent form and have the client sign one, after which you will sign as MFT Trainee, and place the form in the Clinic Director’s hanging file. After it has been signed, it will be returned the Trainee.
FORM:  AUTHORIZATION FOR MULTIPLE TREATMENT MODALITIES  

PURPOSE: To determine appropriateness of client being seen in more than one modality (e.g., individual and marital or adolescent and family)  

WHO: Any client requesting to be seen in more than one modality  

WHEN: When appropriate  

There are times when clients can best be served by treatment within multiple modalities, and times when this type of complexity will cause serious problems. For example, it might be best to treat adolescents with some combination of individual and family therapy carried out by two therapists working together. On the other hand, treating individuals who are also being seen in couples counseling simultaneously can potentially lead to problems including detouring of conflict, negative triangulation, or perceived breaches of confidentiality.

If a client requests to add another modality to their therapy, or if a Trainee believes that the client would benefit from an additional modality of therapy, the following steps must be completed.

The current Trainee will complete the form, Authorization for Multiple Treatment Modalities, and review it with his/her Supervisor. A clear rationale must be demonstrated for adding a modality (e.g., the client’s desire for additional therapy alone does not suffice).

If the Supervisor concurs that the client will clearly benefit from adding a modality, he/she will sign the Authorization for Multiple Treatment Modalities form. See copy of form that follows.

The form will then be given to the Clinic Director for review. If approved, she will also sign the Authorization for Multiple Treatment Modalities form. At that time, the new modality will be assigned to a Trainee and the initial session will be scheduled.

NOTE: No session is to be scheduled for the new modality without the review and approval of the Clinic Director.
The issues of confidentiality and how and when information may be released or disclosed is covered in detail in the Ethics course of the MFT program and is too extensive to be covered in detail in this manual.

Whenever a client requests that information be released by the MFT Trainee to another party, whether verbally or in writing, or a trainee is contacted by another party regarding a client, the Trainee must consult with their Supervisor regarding the request and legal and ethical guidelines to ensure that all appropriate steps have been followed and releases have been obtained.

It is a general Center policy that releases will be obtained from clients for all prior psychotherapy, psychiatric hospitalizations, and psychiatrists/physicians who have prescribed psychotropic medications.

RELEASE OF INFORMATION:

If a client requests that information from his file be forwarded to another professional (i.e., therapist, psychiatrist, attorney), you must discuss the request with your Supervisor prior to any action being taken.

If you receive a telephone call from another professional regarding a client, you may not return the telephone call until consulting with your Supervisor regarding confidentiality and legal and ethical issues. **NEVER RETURN A CALL TO AN ATTORNEY WITHOUT FIRST CONSULTING WITH YOUR SUPERVISOR.**

After discussion with your Supervisor and it is deemed appropriate, have your client complete and sign an **Authorization for Release of Records or Information** form. Even if your client has provided you with a signed release from the other party, it is recommended that you have them sign the **Authorization for Release of Records or Information** form as well.

The **Authorization for Release of Information** form should be completely filled out, dated, and signed.

The signed **Authorization for Release of Information** form and information to be released should be given to the Clinic Director for final review and photocopying.

Your process notes should reflect that the **Authorization for Release of Information** form was signed, and a copy maintained for the file.
REQUEST FOR INFORMATION:

When requesting information from other professionals (i.e., previous therapist, psychiatrist, hospital records, medical doctor), you must complete the Authorization for Release of Records or Information form in its entirety, then have your client date and sign it. You then sign as the witness.

If the client does not know the full address of the other party, you may have to search for it by internet, information, or the telephone book.

DO NOT ALLOW YOUR CLIENT TO TAKE THE FORM HOME TO COMPLETE AS THE CLIENT WILL PROBABLY NOT BRING IT BACK. Instead, fill in the known information, have the form signed, then tell your client you will call them and get the missing information over the telephone.

After the Authorization for Release of Information form is complete, attach it to a letter request so that the Department Assistant can prepare the appropriate cover letter. After obtaining all signatures, a copy of the release and the cover letter will be mailed to the provider. A copy of the letter and the original Authorization for Release of Information form will be maintained in the client’s file.

RELEASE OF VERBAL COMMUNICATION:

At times, you may want to consult verbally with another professional rather than obtain (or release) written material. Examples of this include talking to a school teacher regarding a child client, or speaking with a psychiatrist who is currently treating one of your clients.

Complete the Authorization for Release of Information in its entirety and have the client sign it. Then attach it to a letter request form and the Center Assistant will prepare the appropriate cover letter. After obtaining all signatures, a copy of the release and the cover letter will be mailed to the provider. A copy of the letter and the original Authorization for Release of Information form will be maintained in the client’s file.

Your process notes should reflect that the Authorization for Release of Information form was signed and mailed. You will then document your conversation with the other professional in your process notes.

When talking directly to a client’s psychiatrist or physician, you can use the form, “Psychiatric/Physician Telephone Consultation” form to document your conversation. This form outlines specific information you should ask re: your client’s care.
When the identified client is a child or adolescent, the parent should complete the Child/Adolescent Intake Form prior to the initial session. The purpose of this is to gather more extensive developmental history, and provide information that you can question further during the course of the session.

This form is 3 pages but does not require extensive narrative. It should be utilized as a means of highlighting areas that require further questioning, as well as giving a broad-based context for the presenting issues.

When the parent has completed the form and handed it to you, please take a moment to review all 3 pages to insure that it has been completely filled out and signed.

It is not recommended that you send the form home with the parent as many times the form will not be returned.
When treating a minor child/adolescent, it is the Center’s policy to obtain the consent of both parents in cases where the parents are separated, divorced, or never married, whenever possible and appropriate. While custody documents may allow one parent to obtain therapy without the consent of the other parent, generally it is in the child’s best interests to have the consent and agreement of both parents prior to the commencement of therapy. This can reduce the possibility of one parent interfering or actually rendering the child’s therapy ineffective.

This form is to be completed and signed by the parent who has initiated therapy. Appropriate documents are to be provided when indicated. By completing and signing this form, the parent is doing so under penalty of perjury, which then absolves the Center of any potential legal issues if the parent is not truthful or fails to disclose pertinent information.

Depending on the circumstances, one parent may sign or both parents may need to sign a separate form. The Clinic Director will advise you as to what signatures are needed based on the circumstances and the related laws.
FORM: CLIENT CENTERED ADVOCACY NOTE

PURPOSE: Any activity related to accessing additional support or services in support of the client’s treatment plan

WHO: Any client

WHEN: During the course of therapy

According to Business and Professions Code (BPC) Section 498.80.34(h), client-centered advocacy is defined as including, but is not limited to “researching, identifying, and accessing resources, or other activities, related to obtaining or providing services and support for clients or groups of clients receiving psychotherapy or counseling services.”

These hours are separated out of face-to-face therapy and recorded on a separate section of the BBS Weekly Summary of Hours of Experience.

The purpose of this form is to ensure that such activities are documented in the file, as they are generally done outside of session. In addition, the form serves as a reminder to the Trainee to keep track of these hours for purposes of recording.

Examples of CCA activities include, but are not limited to:

- Identify/research support groups
- Identify/research psychiatric evaluation
- Identify/research low cost medical services
- Identify/research low cost legal services
- Identify/research psychoeducational class
- Identify/research substance abuse treatment program
- Identify/research other adjunctive services
- Telephone call to advocate for client with another professional (with a signed release)
FORM: CLIENT CONTACT LOG
PURPOSE: Document all telephone contacts with client and/or professionals
WHO: Every call to and from client
WHEN: After every telephone contact

From the moment you make the initial call to a new client to set up an appointment, you must document all telephone conversations with a client. The Client Contact Log should include the date and time of the call and a brief description of the purpose and content of the call. (See Appendix)

Example: 9/27/10 – 6:30 pm Called client at home to schedule initial appt. Appt. set for Monday, 10/7/06, at 5:00 pm. Gave client directions and where to park. Client to arrive 30 minutes early for paperwork.

If you place a call to a client but do not reach him/her, you must document the attempt. Follow the same instructions as above.

Example: 9/27/10 – 10:30 am Called client at home to schedule initial appt. Left message on VM including my VM number/extension, with available times: 10/4/06 at 10:0 am or 10/6/06 at 1:00pm.

If you receive an emergency call or lengthy message on your voicemail, you must document the call. The note should include the date and time of the call, content of the call, and your response.

Example: 10/2/10 – 10:15 pm Called at home by answering service – ER call from Client. Returned call immediately to client at home. Client crying and upset, reports she and husband just had a fight and he told her he wants a divorce and walked out. Client made several statements that marriage seems hopeless and she feels overwhelmed. Assessed suicidality – client denies any suicidal thoughts. “I wouldn’t do anything because of the children.” Scheduled appt. for tomorrow at 3pm. In addition, she agreed to call sister and have her stay overnight.

If you place a call to another professional (WITH APPROPRIATE RELEASE), you must document the date and time of the call, and a brief description of the purpose of the call and any conversation.

Example: 10/1/10 – 9:30 am Placed call to Dr. Redman (psychiatrist) to discuss client’s medication, as she reported feeling Prozac is not alleviating depressive symptoms. He advised client has only been on Prozac for 1 week and may not detect any changes for another 2-3 weeks. His diagnostic impression is dysthymia vs. major depression. He suggested client call him if she has any questions.
FORM: FEE AGREEMENT OR FEE REDUCTION
PURPOSE: To advise a client of their fee and specify the conditions of payment for sessions not cancelled within 24 hours or “no shows”
WHO: Every client or parent/guardian of a minor
WHEN: At the initial session or during the course of therapy

CLIENT FEE INFORMATION:
Each client must sign the Fee Agreement form. This form will be completed and attached to the Initial Intake form when it is assigned to you.

After the client has dated and signed the form, you must also sign it as the MFT Trainee.

After the first session, attach this form to the Agreement for Service/Informed Consent form and all other paperwork into the client’s file, and place it in the Clinic Director’s hanging file for signature.

FEE REDUCTION:
Occasionally one of your clients will indicate that due to special circumstances, they are unable to pay the assessed fee and request a fee reduction. Or, during the Initial Intake, the caller will request a fee reduction. Please follow the guidelines listed below:

Have the client complete the information listed in the box in the center of the Fee Reduction form in its entirety, then date and sign it.

The standard fee reduction is 25% of the assessed fee. A copy of the Client Fee Range form is included in this section. If the client is requesting a fee reduction greater than 25%, please consult with the Clinic Director for direction.

After the client has completed and signed the form, you must also sign it as the MFT Trainee.

Place this form in the Clinic Director’s hanging file for signature.

IMPORTANT: PLEASE NOTE THE FOLLOWING:

Your client must pay for each session – they cannot accrue a balance when their fee has been reduced.

The late cancellation policy applies to a fee reduction.

Remember that the fee reduction has an expiration date – you are responsible for monitoring it and re-evaluating the fee with the client prior to its expiration.
<table>
<thead>
<tr>
<th>FORM:</th>
<th>INTAKE ASSESSMENT FORM (INDIVIDUAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE:</td>
<td>Structured interview questions to gather comprehensive information about the client and the presenting issues</td>
</tr>
<tr>
<td>WHO:</td>
<td>Every client or parent/guardian of a minor</td>
</tr>
<tr>
<td>WHEN:</td>
<td>In the first 1-2 sessions</td>
</tr>
</tbody>
</table>
**FORM:** INTAKE SUMMARY

**PURPOSE:** Gather pertinent information to conceptualize treatment planning, as well as summarize course of treatment

**WHO:** Every client that attends at least one session

**WHEN:** Due to Individual Supervisor after Session #4

This form was created to assist you in the gathering of pertinent information, as well as helping you to conceptualize the treatment plan. For ongoing clients, this form should be completed by session 4, at which time you will review it with your supervisor and obtain his/her signature.

For clients that do not return after 1-2 sessions, the form should be completed as well as a “Treatment Summary.” Please read the sections below for more detailed information.

- Intake Summary
- Treatment Summary

For a new client, the box “Intake Summary” should be checked, as well as completing the additional information requested.

**Presenting Complaints (include description of the problem, when it first occurred, and what the client has attempted to resolve the problem):**

This information will be gathered from 3 places: The telephone intake form, the general intake or child/adolescent intake form, and finally from your initial session with the client. Refer to your client by the word “client,” not their name. Also include the client’s age in parentheses. EXAMPLE: “Client (age 24) is seeking therapy due to depressive symptoms that occurred after the break-up of a 5-year relationship in April 2012.”

**PSYCHOSOCIAL HISTORY:**

This information should be gathered in your initial 1-2 sessions with the client. Please use complete sentences. Do not use slang such as “mom” or “dad.” Instead use “mother” and “father.” Also do not use names; instead, refer to client as “client” and others by their relationship (e.g., sister, brother, paternal grandfather; half-sister, step-brother, etc.).

If you did not get information in a particular category, you should write “no information gathered.” Do not leave it blank or type “N/A.”

**MENTAL HEALTH HISTORY:**

Please be sure to check the appropriate box, as well as fill in the information. If you do not know the dosage of a medication, type “(dosage unknown).” Make sure that you refer to the General Intake form for adults, and the Child/Adolescent Intake form for children and teenagers, as there is information on these forms that must be included.

**ASSESSMENT/TESTING:**

If no testing was done, check the box

- No psychological testing was done.
Then delete the rest of the page.

If testing was done, click the box for the specific test that was administered, list the date, and list the score and level of severity. For example:

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Score</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Depression Inventory-II</td>
<td>8/12/12</td>
<td>43</td>
<td>Severe</td>
</tr>
</tbody>
</table>

For the OQ-45:

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
<th>Date</th>
<th>Change in Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score</td>
<td>8/12/12</td>
<td>9/15/12</td>
<td>▶ Improved (Decrease 14+ pts)</td>
</tr>
<tr>
<td>(Total &gt;63 = Dysfunctional)</td>
<td>Total = 85</td>
<td>Total = 60</td>
<td>No Change</td>
</tr>
<tr>
<td>Symptom Distress</td>
<td>SD = 45</td>
<td>SD = 35</td>
<td>▶ Improved (Decrease 10+ pts)</td>
</tr>
<tr>
<td>(SD &gt; 36 = Dysfunctional)</td>
<td></td>
<td></td>
<td>No Change</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>IR = 25</td>
<td>IR = 14</td>
<td>▶ Improved (Decrease 8+ pts)</td>
</tr>
<tr>
<td>Relationship</td>
<td>(IR &gt; 15 = Dysfunctional)</td>
<td></td>
<td>No Change</td>
</tr>
<tr>
<td>Social Role</td>
<td>SR = 15</td>
<td>SR = 11</td>
<td>▶ Improved (Decrease 7+ pts)</td>
</tr>
<tr>
<td>(SR &gt; 12 = Dysfunctional)</td>
<td></td>
<td></td>
<td>No Change</td>
</tr>
<tr>
<td>Critical Items:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide (#8)</td>
<td>2</td>
<td>0</td>
<td>0=Never 3=Frequently</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>0,1,0</td>
<td>0,0,0</td>
<td>1=Rarely 4=Almost Always</td>
</tr>
<tr>
<td>(#11,26,32)</td>
<td></td>
<td>1</td>
<td>2=Sometimes</td>
</tr>
<tr>
<td>Violence at work</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(#44)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DIAGNOSIS:

Include the appropriate DSM-5/ICD-10 codes.

Diagnostic Summary: List each diagnosis given, then list the client’s specific symptoms that have led you to give this diagnosis. DO NOT COPY THE DSM-5/ICD-10.

CASE CONCEPTUALIZATION/TREATMENT PLAN:

Begin with a single paragraph that summarizes your understanding of the most relevant factors explaining your client’s complaint(s). Next, list a general treatment approach you will be using. Try to select a primary approach, even if your plan will be somewhat eclectic. Then identify the client’s treatment goals, ideally in his or her own words as gathered during your assessment. Assist your client in being as specific and objective as possible in articulating his or her goals.

For example ask: How exactly will we know when your therapy is completed?” You may list between one and three distinct goals.

Finally, identify the most important strategies or techniques you will be using to assist the client in reaching these goals.

REFERRALS/CLIENT CENTERED ADVOCACY:
If you have referred the client for any outside services, please note by checking the appropriate box and listing specific information.

**INTAKE SIGNATURES:**

This is to be dated and signed by you, then reviewed with your Individual Supervisor, who will also date and sign it. It is then filed in the client file behind the Supervisor Notes (left side of file).
A Mental Status and History form is to be completed for every client seen at the Center after the initial session. If a couple is being seen, a separate form should be completed for each individual.

Remember to write down the client’s name, your name (as observer), and the date of the observation. The date is important, as it is the client’s mental status on that date.

Complete the form thoughtfully and in a detailed fashion. The purpose is to help you to focus on the client’s non-verbal cues and other behavioral aspects separate from the history you are gathering.

If during the course of treatment you notice a dramatic change in your client’s mental status (either positive or negative), you should complete a new Mental Status and History form.
<table>
<thead>
<tr>
<th>FORM:</th>
<th>PSYCHIATRIC/PHYSICIAN TELEPHONE CONSULTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE:</td>
<td>To identify general information needed when talking to a client’s prescribing physician</td>
</tr>
<tr>
<td>WHO:</td>
<td>Every client who is on psychiatric medications</td>
</tr>
<tr>
<td>WHEN:</td>
<td>After the initial session</td>
</tr>
</tbody>
</table>

Many of the Center’s clients are on psychiatric medications when they begin therapy, or are referred for medication during the course of therapy. The purpose of this consultation form is to enable the Trainee to know what information he/she should gather, at a minimum, from the prescribing physician. It also acts as documentation of the telephone call for the chart, thereby not requiring a separate entry.

It is the standard of practice to first send to the physician a copy of the signed Authorization for Release of Records or Information form. This can be done by fax or by mail. (See section on “Correspondence” on how to generate a cover letter for the Authorization for Release of Information form).

Once this is done, the Trainee can call the physician’s office and request to talk to him/her. In general, physician’s return calls either during the lunch hour or at the end of the day. So as to avoid “voice mail tag,” it is suggested that you ask what would be a good way to reach the physician (what is their practice of taking telephone calls?) If the physician is going to call you back, you can give him/her your cell number. This is acceptable because this is another professional, not a client.

In general, the information needed is the following:

- Is the prescribing physician a psychiatrist or some other specialty?
- What are the psychiatric medications being prescribed, along with the dosage of each?
- What is the diagnosis that the physician has given to the client?
- Is there any other information that the physician thinks would be helpful for the treating therapist (you, the Trainee) to know in order to effectively coordinate treatment?
FORM: SESSION AND FEE RECORD

PURPOSE: To record a client's attendance and fees paid

WHO: Every client

WHEN: After each session or cancellation/no-show

Complete and accurate documentation includes the payment of fees. The Session and Fee Record was developed to not only keep an accounting of monies collected and a running balance, but also to provide a quick visual of the client's consistency in attending therapy. By recording not only the dates of sessions, but also the dates of cancellations, late cancellations, and no shows, you can see the client's attendance pattern as well.

As the file is a legal document, the Session and Fee Record must be accurate! The dates listed must coincide with the date of the process notes regarding sessions, cancellations and no shows.

Remember to log onto this form any cancellations, late cancellations (less than 24 hours’ notice), and no-shows, BUT DO NOT NUMBER THEM! Only number an actual session. For example:

<table>
<thead>
<tr>
<th>SESSION #</th>
<th>DATE OF SVC</th>
<th>PREV BALANCE</th>
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<th>PAYMENT</th>
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Session notes are important in the conscientious effort to record the therapeutic process of the MFT trainee-client interaction. They are also important in the event of an emergency where another trainee must handle a crisis, or in the transfer of the client to another trainee. They also qualify as medical and legal documents, and so must provide an accurate and objective record of events that have occurred during the course of treatment. Records must be accurate in terms of logging all sessions or contacts with the client, including correspondence and telephone calls, to protect the trainee in the event of possible litigation.

Session notes are not gossipy records of “events of the week.” Although significant events are important for you to know and remember, extreme care must be taken in how they are recorded. Consider whether the information you are about to write would jeopardize the client if the records were ever subpoenaed in court. Also consider the fact that every client has a right to see his or her chart, including reading your case notes. Consider this carefully as you document your observations.

Session notes are the recording of the process of the counseling session – the evaluation of the therapeutic work. They need not be lengthy accounts, but enough information should be recorded to help jog your memory of the movement of therapy and provide a helpful summary of the progress made for your Supervisor and/or successive trainee.

You must complete a session note for every single therapy session within 24 hours of the session to ensure that the information documented is as complete and accurate as possible. Waiting even one day to write a session note can blur accuracy and could result in:

- You forget to document crucial information
- Someone else has to read and understand your notes because you are sick and there is an emergency and they are incomplete
- The record is subpoenaed, and you cannot prove a service was rendered because you failed to document it in the client’s file

A well-written session note should include such issues as:

- Client arrived early, on time, or late to session
- Client’s affect
- Content of session (information gathered, issues, etc.)
- Treatment issues
- Treatment goals
- Homework given and/or reviewed
- Psychological testing completed and scored
- Legal or ethical issues raised in session and how they were addressed
- Any other pertinent information not included in the above

General Considerations:
When using adjectives in your session notes, it is recommended that you use clarifying statements that substantiate your observations. This will help to insure that your entries are as precise and accurate as possible, well as give your words more authority. In addition, there will be less likelihood that the comments may be misunderstood or misinterpreted.

Simply stated, when using an adjective, follow it by the phrase “as evidenced by …”

Examples:

POOR: John is withdrawn.

**BETTER:** John appears withdrawn as he reports that he spends all his time in his room and declines to eat meals with his family.

POOR: Mother reports Sarah was aggressive all week.

**BETTER:** Mother reports Sarah exhibited aggressive behaviors during the previous week, including kicking her brother, slamming doors, throwing toys in her room, and yelling at parents.

POOR: Ann appeared to be suppressing her emotions in session.

**BETTER:** Ann appeared to be suppressing her emotions in session as she frequently would not answer questions about how she was feeling, and instead changed the subject.

1. **NAME:** Client’s name

2. **DATE:** Date of the session

3. **SESSION NO:** Keep track of the session number and write it in the space. Only a session is numbered – if a client cancels or no-shows, that is not numbered.

4. **CRISIS MANAGEMENT:** You must check one of these as applicable.
   a. **None:** No crisis issues – a “typical session”
   b. **Suicide:** Your client has suicidal ideation – discuss how you assessed and what you did in Section 7.
   c. **Violence:** Your client has admitted to thoughts of violence, discloses domestic violence, etc. Discuss how you assessed and what you did in Section 7.
   d. **Abuse:** Your client has disclosed information that requires at least a consult with CPS/APS – discuss how you assessed and what you did in Section 7.

5. **GOAL:** Document the treatment goal(s) from the treatment plan, or goals that are the focus of this particular session.

6. **INTERVENTION:** Document the interventions used in order to help the client reach the goals stated above. Intervention means, what did you do? What service did you provide to help the client attain their goal(s)? Interventions are active, meaning “listening” is not enough. You need to demonstrate that the client’s impairments and/or symptoms are being addressed through the
use of clinical intervention. Indicate the purpose of the intervention(s) and how they relate back to the goals.

7. **RESPONSE:** Document the client’s response (verbal and non-verbal) to the intervention provided. Did the client actively participate? Was the client compliant or non-compliant? A positive response indicates that something is working, while a negative response indicates resistance, or the need to re-evaluate either the goal or intervention. When completing the response section, always back the client’s responses with “as evidence by”.

8. **PLAN:** The plan should address what the trainee and client plan to do between sessions and/or for the next session. This should be more than just "continuing treatment" or "continue next session." The plan section may include the goals in which the trainee and client agree to work on for the next session, may include the date for the next planned session or may document a week that will be missed due to upcoming vacations. It is important to remember that the trainee must follow up with documented plan(s) in future sessions with the client.
   e.g., “Continue with assessment to identify triggers for anger.”

9. **ASSIGNMENTS/HOMEWORK:** If none, put “none.” Otherwise note any homework given to client, request for information, referral made, etc.

10. **REFERRALS:** If none, circle “none.”
   
   a. **None:** If you didn’t make any referrals, check “none.”
   
   b. **Psychiatric:** Any referral for evaluation for psychotropic medication, whether it be to their general practitioner or a psychiatrist.
   
   c. **Medical:** Any referral for physical evaluation, including to rule out a medical condition that may be contributing to a psychiatric disorder (e.g., rule out thyroid problems which might be causing depressive symptoms).
   
   d. **Other:** Any referral to a group, 12-step group, employment counseling, yoga class, etc. Anything you suggest to your client based on your treatment plan.
FORM: SUPERVISOR NOTES

PURPOSE: Legal and ethical requirements re case review

WHO: Every client

WHEN: Minimum of 1 signature per month

It is the Center’s policy that every client’s treatment be reviewed and signed off a minimum of once per month. Obviously you will consult more frequently on clients that require additional attention.

The Supervisor’s Notes are absolutely essential to documenting that you, as a trainee, are receiving adequate supervision and review on your cases.

All client files must have at least one Supervisor’s signature, even if only seen once.

If you receive supervision on a case between the regularly scheduled supervision time, it is your responsibility to see that the supervision is documented appropriately.

It is your responsibility to insure that your cases are reviewed regularly by your Individual Supervisor and obtain signatures as outlined above. Failure to do so may negatively impact your evaluation and may result in more serious repercussions.
FORM:  TELEPHONE INTAKE - INDIVIDUAL
PURPOSE:  To gather initial clinical information on the telephone and assess fee
WHO:  Every person who calls to initiate therapy at the Clinic
WHEN:  During the initial telephone contact and prior to being assigned to an MFT Trainee

This Center is not a walk-in clinic, nor a crisis clinic. While occasionally an individual will walk in to seek counseling, typically a telephone intake is completed before the person is assigned to an MFT Trainee. This allows the Clinic Director to review the presenting issues and determine whether an individual is appropriate for the Center.

Most intakes will be completed by Center trainees as part of their training. The procedure for completing a telephone intake is listed below.

**Today's Date:** The date you are completing the telephone intake.

**Time:** Time of the call.

**Call Taken By:** Your first and last name

**What is your name:** Make sure to get the full name and check spelling. If it is a parent or child, make sure you get the parent's full name as frequently the last names are different.

**What type of counseling are you requesting:** This is self explanatory. If the caller indicates more than one, then check all items accordingly.

**NOTE:** Occasionally a parent may call for an adult child, or a spouse will call to initiate individual counseling for their mate. Advise them that due to the fact that the individual being referred is an adult, he/she will have to call for themselves.

**Client’s Name:** Client’s full name. If caller gives a nickname, ask for the formal name. Examples: Tom vs. Thomas, Debbie vs. Deborah, etc. **ALWAYS CHECK THE SPELLING OF A NAME, NO MATTER HOW SIMPLE IT MAY SEEM.** People often spell their names unusually (e.g., Tom might be Thom, Suzy might be Souxie).

If the individual is calling for marital or couple’s counseling, remember to get both names and birthdates. For families, get the names of all family members and their birthdates.

**Address:** Full address including apartment or unit number, city, and zip code. If a client gives you a P.O. Box, try to get a street address as well. In addition, ask them if this address is the mailing address in case of correspondence.

**Telephone Numbers:** Remember to get the area code for cell number and write legibly. In addition, it is very important to ask the client if it is acceptable to be called or leave a message on this number.

**What is your Current Living Situation:** This question is asked to assess the client’s level of isolation and whether there is any support system.

**Who referred you to the Center:** This is to obtain information on referral sources. If there is a blank next to the category (e.g., Hospital), then get the name if possible. If the individual has been referred by someone currently being seen at the Center, ask the referring person’s name.
NOTE: If referred by the Court, Probation Officer, Attorney, or Social Services, then ask the client specifically what they are being referred for (e.g., anger management classes, substance abuse treatment, etc.). Then ask the client to explain what the events were that led to the referral. If the person hesitates or is vague, explain that the purpose of this question is to determine whether our Center can provide what is being required by the referring agency.

Have you been a client of the Center in the past: This is to determine whether there are Center records to be pulled, or a client number has already been assigned.

Have you been in counseling before: If yes, obtain a general description and approximate dates.

Have you been hospitalized for psychiatric reasons: If yes, obtain the name of the hospital, approximate dates, whether voluntary or involuntary, if there was a suicidal attempt or threat to others, and if they know their diagnosis.

Are you currently on medication: If yes, list the names of the medications (see attached list of common medications for spelling), as well as the dosage.

What is your diagnosis: Also ask if the client knows their diagnosis.

Have you taken psychiatric medications in the past: If yes, list the names of the medications.

Why were you prescribed the medication(s): Ask why the person was put on medications in the past.

Why did you stop taking the medication(s): This is important to get an idea of med compliance, reluctance to be on meds, or other data.

How much alcohol, if any, do you currently drink: Obtain the amount of drinks per day, week, or month.

Example: “Drinks 6-pack of beer daily, a case of beer on weekends.”

Have you had a problem with alcohol in the past: If yes, find out how long ago.

What "street" drugs (illegal), if any, do you use at this time: Obtain the name of the drug and the usage on a weekly basis.

Have you had a drug problem in the past: If yes, obtain information on the drug(s) of choice and how long ago.

Example: “Clean for 6 weeks – using crystal meth approximately 5X a week.”

Have you sought treatment for substance abuse in the past: If yes, find out the name of the treatment provider, city and state, and whether it was inpatient or outpatient.

What is the reason you are seeking counseling at this time: This is one of the most important sections of the intake. Your description should include problem areas, when did the caller first become aware of the problem, and how long has it been going on. Sometimes a quote can be helpful, or ask the caller for an example.

Example:

Caller: I think I’m depressed.
**Intake:** What makes you think you’re depressed? What kinds of things are you noticing that lead you to believe you’re depressed?

**Caller:** Well, I can hardly get out of bed anymore. I’ve also stopped eating. I feel tired all the time.

**When did this problem first occur:**

**Example:**

**Intake:** How long have you been feeling this way?

**Caller:** For a few years, but it’s gotten really bad the last few months.

**Intake:** When did you first notice being depressed?

**Caller:** After my mother died a couple of years ago.

**Intake:** You said you felt it got worse a few months ago. What was going on then?

**Caller:** Well, my daughter moved out.

The written summary would be:

*States she has been depressed since mother died a couple of years ago. Complains of feeling tired, can’t get out of bed, loss of appetite. Since daughter moved out of the house a few months ago, she feels depression has worsened.*

If the caller states they are unwilling to discuss this information with anyone other than their therapist, advise them that you will need a general description of the presenting problem in order to match them with an appropriate counselor. If they still refuse, note this on the form.

**Example:** Caller refused to tell me anything regarding the presenting problem. Will only discuss with assigned counselor.

**Have you had problems hearing things that other people do not hear:** This is to assess potential hallucinations. If “yes,” ask for an example to clarify this information.

**Have your thoughts been feeling strange or out of control:** This is to assess possible mania or other psychotic symptoms. If “yes,” ask for an example to clarify this information.

**Are you having suicidal thoughts now:** Always ask this question, no matter how benign the presenting problem seems to be. If you are talking with the parent of a child, ask, “To your knowledge, is your child having suicidal thoughts or made statements about wanting to hurt himself/herself?”

**If yes, do you have a plan:** Ask this question only if the caller answered “yes” to the previous question.

The primary issue to be differentiated is: (a) if having suicidal thoughts, does the person have a plan? Often individuals have “passive” suicidal thoughts, such as not wanting to wake up tomorrow, but they do not have a plan to make that happen. (b) If the person has a plan, do they have the
means? For example, a caller may tell you he would commit suicide by shooting himself, but he
does not have a gun or access to a gun.

Have you made any suicide attempts in the past: Always ask this question, even if the caller
responded “no” to the question of having suicidal thoughts. If the caller has made an attempt in the
past, ask how many times and obtain the approximate date(s), method(s), did they tell anyone at the
time, and if they were hospitalized as a result.

This is a complex issue to cover all contingencies in a brief paragraph. As part of the Psychology
572 class, you received instructions on how to assess for suicidality and related issues. See the
attached guidelines regarding how to manage a suicidal caller.

IMPORTANT: IF YOU ARE DOING AN INTAKE ON A SUICIDAL PERSON AND NEED HELP –
ASK! EVERY COUNSELOR IN THE CENTER IS HERE TO HELP YOU AND ASSIST IN ANY
WAY THEY CAN.

The important thing is to note the caller’s responses as clearly as possible.

Example: Client admits to suicidal thoughts a few times this week, but has no plan and
states she would never do it “because of my children.”

When are you available for counseling – what days and times: We must know when the caller is
available in order to assign them to a trainee with matching availability. Also, sessions are on the
hour only – not on the half hour (e.g., 5:00 NOT 5:30).

NOTE: Do not let a caller give you only one day and time – always get as many options as possible.

Center Hours are generally: Monday-Friday 9:00 am to 9:00 pm
Saturday 9:00 am to 5:00 pm

Financial Information: As part of informed consent, a caller must know what his/her fee will be prior
to the first session. This fee assessment is part of the Initial Intake form and must be completed.

Read the paragraph listed under the heading “Financial Information” prior to asking for the
financial information.

If the caller indicates that they have no income, ask if they are on unemployment, disability, or some
other benefit, and how much they receive. If the caller states he has no income whatsoever, try to
assess how they are living (i.e., living with a family member, mother is giving them money, etc.). If
they refuse to clarify the financial information, advise them that the Clinic Director will call them to
advise them of the session fee and note this on the form.

If the caller states their income varies from month to month, then ask what is their average monthly
income.

Refer to the Client Fee Range form to quote the appropriate fee.

If the caller states that the fee is too much, advise them they can request a fee reduction which will
be 25% of the stated fee (see the second column on the Client Fee Range form) and quote the
reduced fee. On the Initial Intake form, write both the initial fee, then the fee reduction in
parenthesis.

Example: $24 ($18)
If the caller states he/she cannot afford to pay anything, and they are looking for free counseling, refer them to the 2-1-1 service for referrals.

Read the statement: Although the Center cannot accept insurance, it is helpful to know if you have insurance in the event any referrals are made. Do you have health insurance? If yes, what kind?

Ending the Intake Call: Let the caller know that you will give the intake to the Clinic Director to be assigned. A counselor will contact them within 1-2 days to schedule an appointment.

If the intake appears to be of an urgent nature, tell the caller you will see that the Clinic Director gets the intake as soon as possible and someone should get back to them within the day.

You can then hand the intake form to the Clinic Director or place it in her hanging file. She checks the file several times a day and will review and assign all intakes.

The Clinic Director will review the intake and answer the questions listed at the top of page 1.

The client will be referred out and provided with other referrals by the Clinic Director if:

1. The client is actively suicidal (has intent and plan).
2. The client has been hospitalized for psychiatric reasons within the past year.
3. The client currently has psychotic symptoms (i.e., hallucinations, delusions, or disorganized thinking) that are not adequately managed through psychiatric care.
4. The client has a significant substance abuse problem that requires specific treatment.
5. There are possible legal issues that are beyond the scope of competence/practice (e.g., custody, disability evaluation, etc.).

The client will be seen for an “extended intake assessment” if:

1. The client reports current suicidal ideation or history of attempts made more than 1 year ago.
2. The client has been hospitalized for psychiatric reasons more than 1 year ago.
3. There is a history of psychotic symptoms (but not within the last year and currently on psych meds).
4. The client reports a level of substance use that requires further assessment.

An extended intake assessment is defined as meeting with the trainee and/or supervisor to assess the appropriateness for the Center. The form *Intake Assessment form* will be utilized in session and the trainee will complete all items and review with the Supervisor. If deemed appropriate for the Center, the *Extended Intake Assessment* form will be signed off by the Supervisor and Clinic Director.

If not appropriate, the trainee will meet with the Clinic Director and compile a list of referrals that will provide the needed level of care, and then work with the client to follow through. The *Intake Assessment* form will be signed off by the Supervisor and Clinic Director.

NOTE: If a caller is seeking couple or marital therapy, use the form entitled *Telephone Intake – Couple*.

If a caller is seeking therapy for a child, teen, or family, use the form entitled *Telephone Intake-Child/Family*.
FORM: TREATMENT SUMMARY

PURPOSE: Summary report of client's therapy

WHO: Every client who has been seen for at least one session

WHEN: Within 30 days of transfer or termination

For every client who has been seen for at least one session, a Treatment Summary must be completed and signed by the MFT Trainee, the Supervisor, and the Clinic Director. The information included on the form is a summary of the client’s therapy and includes the following information:

1. Presenting Complaints
2. Psychosocial History
3. Mental Health History
4. Results of Psychological Testing
5. Diagnosis
6. Treatment Plan
7. Referrals
8. Reason for Termination or Transfer
9. Progress of Treatment and Recommendations

At times, the MFT Trainee is graduating and the client has requested to be transferred to another trainee to continue therapy. The Treatment Summary form is to be used, and will include the name of the MFT Trainee that the client has been transferred to.

All Treatment Summary forms are to be completed within 30 days of termination. They should be given to the Clinic Director, along with the file, for review and edits.

For clients that do not return after 1-2 sessions, there is a shorter form that must be completed (Int-Tx Summary 1-2). Please read the sections below for more detailed information.

☐ Intake Summary ☒ Treatment Summary

The box “Treatment Summary” should be checked, as well as completing the additional information requested.

For clients that have been seen for a period of time, you will have already completed the intake summary. This form is then modified to be a “Treatment Summary” and you will only update the information since the Intake Summary. See the section on “Intake Summary” for additional information.

REASON FOR TERMINATION:

Check the appropriate box, as well as fill in the requested information.

PROGRESS OF TREATMENT AND RECOMMENDATIONS:

Again, check the appropriate box and fill in the information requested – do not leave it blank.

Date and sign the Treatment Summary, get the signature of the Individual Supervisor, and give the Treatment Summary and file to the Clinic Director.
CORRESPONDENCE

The Center may be requested to provide correspondence regarding a client's therapy. These requests come from a variety of sources, including the Social Security Administration, attorneys, probation officers, and courts.

The most important rule to remember is this:

**ABSOLUTELY NOTHING MAY BE SENT OUT OF THIS CENTER WITHOUT THE CLINIC DIRECTOR’S REVIEW AND SIGNATURE**

The term "correspondence" is defined as: letters, notes, copy of anything from the client’s file (e.g., copies of testing, notes). This also includes telephone conversations with anyone other than the client (or parent/guardian of a minor) whether the MFT Trainee places the call or is asked to return a call.

The reason for this is to ensure that you, the MFT Trainee, do not violate any legal or ethical guideline that could result in liability against you, your supervisor, or the Center.

The issue of scope of practice/competence is also a factor. For example, a parent may request that you send a letter to their attorney documenting that he/she is the better parent (parent is in a custody battle); letter to a probation officer that a client dealing with anger issues is “cured” and the anger no longer an issue. **THE CENTER DOES NOT PROVIDE ANY TYPE OF EVALUATION. AS AN MFT TRAINEE, YOU DO NOT HAVE THE EXPERIENCE OR TRAINING TO PROVIDE ANY TYPE OF EVALUATION.**

The purpose of this section is to review some of the more typical requests and how to follow safe guidelines.

**STANDARD CORRESPONDENCE**

In addition to the above, there are a variety of standard letters that have been created to send to clients about routine issues such as:

- Client has not responded to telephone calls to schedule appointment
- Client scheduled appointment but did not show up.
- Client has not been seen in quite a while and you are not sure if they are still interested in therapy
- Client terminated therapy over the telephone
- Client has stopped therapy and has a balance

Letter templates are located in the “Shared Clinic Files” folder with a short cut located on the desktop of the computers in the clinic. All letters are to be prepared and signed by the Trainee and then given to the Clinic Director to sign. The Department Assistant will then copy the letter for the file and mail the original. If the letter is to include a signed release, the original signed release should be paper-clipped to the back of the letter. For specialized letter please consult with your Supervisor or the Clinic Director. The Department Assistant can help draft a specialized letter.
ATYPICAL CORRESPONDENCE

If you are requested by a client to provide a letter or report regarding the client’s therapy to another professional, or you receive a request for information through the mail, follow the steps outlined below:

Gather a full description of what is being requested. This will include:

Who is the letter to be sent to? Full name and mailing address. “To Whom It May Concern” is not acceptable. If the client does not have an individual’s name, get the full name of the agency. If the request is going to an agency without a name to send to the attention of, you should try to get a client number, case number, or some other identifying information.

What information is being requested? For example: a summary of treatment, recommendations, etc. Ask the client what the purpose of the request is. This will help to understand what is being requested, and whether you can follow through with the request.

Have the client complete (in its entirety) and sign the Authorization for Release of Records or Information form at the time the request is made. (See Appendix) Then advise the client you will review the request with your Supervisor and that the Clinic Director must sign off on all correspondence.

If the client states that the document is needed immediately (today or tomorrow), TELL THE CLIENT YOU ARE UNABLE TO DO IT. PERIOD. Do not get pressured into doing something that may result in you doing something that is (unknowingly) unethical or illegal.

Review the client’s request with your Supervisor. The review should include:

1. Is it appropriate?
2. Has proper consent been obtained?
3. Review a draft of the correspondence.

If the request is deemed appropriate and the draft is approved by your Supervisor, submit the draft to the Department Assistant for typing, along with a copy of the signed Authorization for Release of Information form. The letter will not be prepared unless a copy of the Authorization for Release of Information form is attached. The Clinic Director will then co-sign the letter, a copy made for the file, and the original mailed by the Department Assistant.

If your Supervisor believes the request to be inappropriate (e.g., outside your scope or there are clinical reasons), discuss how to inform the client that you are not able to provide the document and why.

Document all information in the client’s file: The client’s request, the signed Authorization for Release of Information form, discussion with your Supervisor, a copy of the letter, and any conversations with the client.

If you receive a request for a copy of records, forward the request and the client’s file to the Clinic Director. YOU ARE NEVER TO COPY A FILE OR ITS CONTENTS AND SEND THEM TO ANOTHER PARTY.
RECORDING A SESSION

At the beginning of your one-year practicum, you will be assigned a folder on the Clinic's secure network drive (short cut located on the desktop of all computers in the clinic). Your recorded sessions will be kept here and only here. Video recording equipment is a small black VidiU broadcasting device designed by Teradek.

All recording equipment is located in the Observation Room. Before starting your recording, ensure that the black device says “Ready” (if it says “no video” or “not ready” do not record). Start the recording by clicking the top button. Once you see the prompt “Begin recording?” click the top button again. At the end of your session you will need to return to the Observation Room to stop the recording. Click the top button again for the prompt “do you want to stop recording?” Using the top button, toggle to the right to select “yes” and click the button one last time. The device will go back to “ready” and your session has stopped recording.

Each morning the Department Assistant labels the sessions and sorts them into the student files. Please note your recordings are available the next day, but can be sorted sooner within reason by request.
TESTS AVAILABLE

The following is a list of tests available for your use in the Center:

- Aggression Questionnaire
- AUDIT Self Report
- AUDIT Interview
- Beck Anxiety Index (BAI)
- Beck Depression Inventory (BDI-II)
- Beck Hopelessness Scale (BHS)
- Child Behavioral Checklist (CBCL-II)
  - Ages 1-1/2 to 5: Parents
  - Ages 1-1/2 to 5: Caregiver-Teacher
  - Ages 6 to 18: Parents
  - Ages 6 to 18: Teacher
  - Ages 11-18: Youth Self Report
- Conflict Tactics Scale
- Dyadic Adjustment Scale
- Major Depression Inventory (ICD-10)
- Marital Satisfaction Inventory (MSI-R)
- Mood Disorder Questionnaire
- NEO-PI-R (Personality Inventory)
- Outcome Questionnaire (OQ-45.2)
- Parenting Stress Index (PSI)
- Quality of Life Inventory (QOLI)
- Youth Outcome Questionnaire (YOQ 2.01)
- Youth Outcome Questionnaire (YOQ-SR 2.0)

The following tests are available in Spanish:

- Beck Anxiety Index (BAI)
- Beck Depression Inventory (BDI-II)
- Beck Hopelessness Scale (BHS)
- Child Behavioral Checklist (CBCL-II)
  - Ages 6 to 18: Teacher
  - Ages 11-18: Youth Self Report
- Outcome Questionnaire (OQ-45.2)
- Youth Outcome Questionnaire (YOQ and YOQ-SR)

In addition, we have a 2-volume set of short assessments on a variety of issues:

- Measures for Clinical Practice (Vol. 1): Couples, Families, and Children
- Measures for Clinical Practice (Vol. 2): Adults
The Center has developed an in-house library including books, manuals, DVDs, and videotapes on a variety of topics. These include but are not limited to:

- Abuse and Trauma
- Acceptance and Commitment Therapy (ACT)
- Addictions
- Aging
- Anger
- Anxiety Disorders
- Behavior Modification
- Child/Adolescent Treatment
- Child Books on variety of issues (anger, jealousy, fear, etc.)
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavioral Therapy (DBT)
- Diversity
- Domestic Violence
- Emotionally Focused Therapy (EFT)
- Eating Disorders
- Family Therapy
- Genograms
- Interpersonal Theory
- Marital Therapy
- MFT Practice
- Mood Disorders
- Multicultural Therapy
- Multigenerational Therapy
- Pain Management
- Parenting
- Personality Disorders
- Psychopharmacology
- Self Esteem
- Sexual Abuse
- Stress Management

All items can be checked out by any Center trainee. In order to check out an item, ask the Department Assistant for the library key and fill out the enclosed 3X5 card with your name and the date and place it in the small card file on the shelf.
CLIENT THERAPY FORMS

The Center has a variety of forms that can be utilized with clients during the course of their therapy. A list of these forms is below.

- Activity Record
- Anger Assessment
- Attendance Contract
- CBT Worksheet
- Evidence Record
- Feeling Words
- No Violence Agreement
- Safety Plan
- Substance Abuse Survey
- Thought Record
- Time Out – Client Guide
- Time Out – Therapist Guide

In addition, the computer disk for the book, “Acceptance and Commitment Therapy” is available in the Center library for most of the ACT techniques.
REPORTING CHILD AND DEPENDENT ADULT/ELDER ABUSE

Due to the complexity and range of this issue, you are to refer to current laws and regulations regarding the reporting of abuse.

During the course of therapy, if the issue of abuse is raised, you are to contact your Individual Supervisor as soon as possible to consult. There are many issues to address, including legal, ethical, client safety and welfare, clinical, documentation, and many more, not the least of which may also be managing your own anxiety.

Local reporting agencies are:

Child Protective Services: 714-940-1000 (hotline)
800 N. Eckhoff    714-938-0289 (fax number)
Orange, CA 92863

When reporting abuse, call to CPS is to be made as soon as possible after becoming aware of possible abuse. If a report is taken, the written report is required to be mailed within 36 hours; however, if instructed to fax the report, it is not necessary to send a written report as well. **Always get the name of the individual you spoke with at CPS. If told that a report is not necessary, get the person’s name and the reason given for no report and document this in the file.**

Adult Protective Services: 714-825-3030
P.O. Box 22006    714-825-3001 (fax number)
Santa Ana, CA 92702

When reporting abuse, call to APS is to be made as soon as possible after becoming aware of possible abuse. If a report is taken, the written report is required to be mailed within 2 business days. If instructed to fax the report, it is not necessary to send a written report as well. **Always get the name of the individual you spoke with at APS. If told that a report is not necessary, get the person’s name and the reason given for no report and document this in the file.**

“Suspected Child Abuse Report” and “Report of Suspected Dependent Adult/Elder Abuse” forms are located in the file form trays. (See pages 194 and 172, respectively)

You must also familiarize yourself with the University's Policy on Mandated Reporters and Required Reporting of Abuse and Neglect which is available at:

[https://mywindow.chapman.edu/depts/hr/Documents/Mandated%20Reporter%20Policy%20June%202015%20FINAL.pdf](https://mywindow.chapman.edu/depts/hr/Documents/Mandated%20Reporter%20Policy%20June%202015%20FINAL.pdf)

The University Policy on Protecting Minors which is available at:

[https://mywindow.chapman.edu/depts/hr/Documents/Protecting%20Minors%20June%202015%20FINAL.pdf](https://mywindow.chapman.edu/depts/hr/Documents/Protecting%20Minors%20June%202015%20FINAL.pdf)

**NOTE:** Whenever making a report or a consultation call, you must notify your Individual Supervisor at that time. **DO NOT** wait until supervision to do so.
SUGGESTED GUIDELINEES FOR DEALING WITH SUICIDAL CLIENTS

As an MFT Trainee, you have an ethical and legal responsibility to follow these procedures when you become aware of potentially suicidal behavior on the part of a client.

Doing therapy with a suicidal client can be an unnerving experience, particularly the first time. There are many issues to cover: legal, ethical, client safety and welfare, clinical, documentation, and many more, not the least of which can be managing your own anxiety.

The information outlined in this section is merely a guide to some of the more important areas to cover. It is expected that you will be consulting with your Individual Supervisor frequently should a client become suicidal.

EVALUATION:

As part of the assessment of potentially suicidal behavior, you should immediately advise and consult with your Individual Supervisor or the Clinic Director.

As part of the assessment, you should assess the level of suicidal ideation. While there is no definitive measure to make such an assessment, attached is a suicide risk assessment worksheet that will aid in making such an evaluation.

After consulting with your Individual Supervisor or the Clinic Director, a decision will be made as to the level of risk, and appropriate steps you should take to manage the case. These steps are outlined in the following pages.

NOTE: The process of evaluation should be continuous in order to add all relevant information and changes in the circumstances in the case. You should maintain frequent contact with your Individual Supervisor and/or the Clinic Director until such time as the client is deemed to be “safe.”

CLIENTS AT LOW RISK (e.g., ideation only without intent, plan, or past attempts):

Continue to monitor suicidal ideation weekly in session.

Make a written safety plan with the client.

Administer the BHS at each session to monitor the level of hopelessness.

Work with the client to reduce risk factors:
- Increase social contacts
- Increase physical activity
- Decrease (or eliminate) any alcohol/substance use

Discuss with your Individual Supervisor if a medication referral is appropriate. If the client is on medication and under the care of a psychiatrist or physician, get a release signed and consult immediately.

ALL steps taken and any consultations with your Individual Supervisor, Clinic Director, or other professionals must be documented promptly and thoroughly.
CLIENTS AT “MEDIUM” RISK (ideation with a plan, no intent, no past attempts):

Continue to monitor suicidal ideation weekly in session.

Make a written safety plan with the client.

If the client has a plan, have the client remove access to the means.

Consider increasing the number of sessions per week until the crisis symptoms stabilize.

Administer the BHS and BDI-II at each session.

Discuss with your Individual Supervisor whether family members or friends should be enlisted to increase the client's safety. This will involve the issue of confidentiality and whether it can be breached due to safety and welfare issues.

Work with the client to reduce risk factors:

- Increase social contacts
- Increase physical activity
- Decrease (or eliminate) any alcohol/substance use

Refer to a psychiatrist for evaluation immediately.

If the client is on medication and under the care of a psychiatrist or physician, get a release signed and consult immediately. NOTE: You may not need a release, depending upon the client's level of suicidality. Consult with your Individual Supervisor and/or the Clinic Director.

ALL steps taken and any consultations with your Individual Supervisor, Clinic Director, or other professionals must be documented promptly and thoroughly.

CLIENTS AT “HIGH” RISK (e.g., ideation with intent or past attempts):

If a client is considered at “high” risk for suicide, a thorough plan is mandatory and should try to include family members or other support system (if available). You should be consulting closely with your Individual Supervisor to insure that all steps are taken to minimize any risk to the client.

Please review the following steps as guidelines for a client assessed to be at “high” risk:

If under the care of a psychiatrist, call him/her immediately and notify the psychiatrist of the emergency. Consult with the psychiatrist regarding where the client should go (where the psychiatrist can arrange to meet the client or have the client evaluated.)

You should attempt to get the client to go to the nearest hospital for evaluation and voluntary hospitalization. Part of the assessment may be to determine whether the client is “safe” to drive. If not, you should see if there is a family member or friend that can transport the client. DUE TO LIABILITY – YOU MAY NOT TRANSPORT A CLIENT TO THE HOSPITAL.

If the client refuses to go voluntarily or the client is not safe to drive himself/herself and there is no one who can transport, then call the County’s P.E.T. team or 9-1-1 and request emergency assistance. Only a designated county employee or police officer can initiate the “51/50” process (involuntary hospitalization).
DEALING WITH POTENTIALLY VIOLENT CLIENTS

As an MFT Trainee, you have an ethical and legal responsibility to follow these procedures when you become aware of potentially violent behavior on the part of a client.

Doing therapy with a potentially violent client can be an unnerving experience, particularly the first time. There are many issues to cover: legal, ethical, client safety and welfare, duty to warn, clinical, documentation, and many more, not the least of which can be managing your own anxiety.

The information outlined in this section is merely a guide to some of the more important areas to cover. It is expected that you will be consulting with your Supervisor frequently should a client express violent intentions.

EVALUATION:

As part of the assessment of potentially violent behavior, you should immediately advise and consult with your Individual Supervisor or the Clinic Director.

As part of the assessment, you should assess the level of threat. After consulting with your Individual Supervisor or the Clinic Director, a decision will be made as to the level of risk, and appropriate steps you should take to manage the case.

NOTE: The process of evaluation should be continuous in order to add all relevant information and changes in the circumstances in the case. You should maintain frequent contact with your Individual Supervisor and/or the Clinic Director until such time as the client is deemed to be “safe.”

In addition, you may want to utilize the “No Violence Safety Agreement” as a therapeutic instrument.
PSYCHIATRIC REFERRALS

In general, a full psychiatric evaluation will cost $300-$400, with follow-up 15-minute “med evaluations” at approximately $90-$115 each. Because many of our clients are low income, this obviously becomes a tremendous obstacle. Therefore, please read all of the following carefully and review it with your supervisor. Keep this information to refer to with your caseload.

Attached for your review and use are the following:

1. A decision tree to review for each client that you are referring for a psychiatric evaluation

MAKING A PSYCHIATRIC REFERRAL

Please review the “Psychiatric Referral” form when you need to refer your client for a psychiatric referral. (See page 171) By answering ALL the questions, you should be able to determine the best referral source based upon your client’s needs and access to treatment. If none of these referrals are appropriate (i.e., all answers are “NO”), see your Individual Supervisor or the Clinic Director. In addition, there is information for the client on what is involved in a psychiatric evaluation.

REMEMBER: If your client has Medicare or Medi-Cal (Cal Optima), you can go to the website for the O.C. Psychiatric Society (www.ocps.org) and search for a psychiatrist that accept Medicare and/or Medi-Cal.

PSYCHIATRIC MEDICATIONS

For clients that are having trouble paying for their psychiatric medication(s), refer them to Patient Assistance Programs (PAPs) such as www.rxhope.com, www.needymeds.com, etc. These are Patient Assistance programs funded by the pharmaceutical companies for clients that cannot afford their medications. Their doctor’s office will fill out the application and they may receive their medications for free or at a reduced cost. This information is also included on the Psychiatric Referral form.
SUBSTANCE ABUSE SERVICES

If a client presents with a significant substance abuse problem, the client may be referred out for services due to scope of practice issues. Substance abuse is a common problem, and the accurate assessment of a client’s use of substances (alcohol, prescription drugs, and illegal drugs) is extremely important.

At times we may allow a client to be seen at the Center if he/she is concurrently enrolled in specific substance abuse treatment program. Depending on a client’s financial ability to pay, some may utilize insurance benefits. For many of our clients, this is not an option.

ADDITION TREATMENT CENTERS

Since the implementation of MHSA programs and subsequent budget cuts, the O.C. Drug and Alcohol programs have drastically cut their services. The Addiction Treatment Centers (ATC) have locations in Fullerton, Garden Grove, and Huntington Beach. You can call them at 714-992-1677 and get information on the best way to refer a client. As part of their services, they can receive individual and group therapy and they charge on a sliding scale, and will work with referrals. If the individual has a dual or co-occurring diagnosis, he/she is referred to MHA to a psychiatric evaluation and medications.

SUBSTANCE ABUSE SURVEY

In addition to the listing of locations is a form entitled “Substance Abuse Survey” which will assist you in the assessment of abuse/dependence for your clients. Ongoing consultation with your Supervisor is required.
MISCELLANEOUS REFERRALS

“Client Advocacy” is defined in Business and Professions Code (BPC) Section 4980.34(h) as including, but not limited to “researching, identifying, and accessing resources, or other activities, related to obtaining or providing services and supports for clients or groups of clients receiving psychotherapy or counseling services.” Effective 1/1/2010, the BBS now allows trainees and interns to count these hours.

During the course of your practicum you will be locating adjunctive services for your clients in a variety of areas. For example, your client may need a depression support group, a low cost psychiatric referral, or the location of a food bank. These types of services often change due to funding and other factors.

2-1-1 OC

In 2008, the state of California devised a referral service throughout California entitled “2-1-1.” Any California resident can dial 2-1-1 from their telephone and reach this service. This agency is staffed by bilingual operators who can provide referrals for anything related to human services in the local county. This includes: low cost housing, food banks, low cost medical services, shelters, support groups, low cost therapy, etc. This is an excellent source for locating these types of services for your clients.

HURTT FAMILY HEALTH CLINIC – ORANGE COUNTY RESCUE MISSION

The Hurtt Family Health Clinic provides highly accessible, preventative, primary and specialized healthcare to homeless and underserved families through a full service medical, dental, and eye care clinic located on the Village of Hope Campus in the City of Tustin. They have also recently added low cost psychiatric care.

SERVING OUR SELVES (SOS)

Another service is an organization entitled “Serving Our Selves” or “SOS.” It is located in Costa Mesa and provides medical, legal, food, and other services on a first-come, first-served basis.
ACKNOWLEDGEMENT OF CENTER POLICY RE: OUTSIDE EVALUATIONS

NAME: ____________________________________________

Print name

I understand that this is a training clinic and my therapist is NOT able to provide the following services, written or verbal:

(1) child custody evaluation;

(2) any court evaluation;

(3) social services evaluation;

(4) probation or parole evaluation;

(5) workers compensation/disability evaluation; or

(6) any other type of evaluation which may require testifying in court.

Furthermore, I will let my therapist know immediately if I require these types of services so that appropriate outside referrals can be provided to me.

By my signature below, I certify that I have reviewed the information and I have been given the opportunity to ask questions and have them answered. I fully understand and agree to the information contained in this document.

Dated: ________________________  ________________________

Signature of Parent/Guardian

Dated: ________________________  ________________________

Signature of Parent/Guardian

Dated: ________________________  ________________________

Signature of MFT Trainee
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<th>THURSDAY</th>
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<th>SATURDAY</th>
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**FRANCES SMITH CENTER FOR INDIVIDUAL & FAMILY THERAPY**  
**ADULT GENERAL INTAKE INFORMATION**

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<thead>
<tr>
<th>Name:</th>
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<th>Today’s Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td></td>
<td>Date of Birth:</td>
</tr>
</tbody>
</table>

**Gender:**
- [ ] Male  
- [ ] Female  
- [ ] Transgender  
- [ ] Self-Identity (please specify) 

**Marital Status:**
- [ ] Single  
- [ ] Married  
- [ ] Separated  
- [ ] Divorced  
- [ ] Partnered

**Address:**

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<thead>
<tr>
<th>Street Address</th>
<th>Apt. Number</th>
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</thead>
<tbody>
<tr>
<td>City</td>
<td>State</td>
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</tbody>
</table>

**Telephone:**
- [ ] Home: ( )  
- [ ] Work: ( )  
- [ ] Cell: ( )

**Child(ren) in the home:**
- [ ] YES:  
- [ ] NO If yes, list names and dates of birth below:

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<th>DOB:</th>
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<th>DOB:</th>
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</table>

**Ethnic Identification:**
- [ ] Alaskan Native  
- [ ] Central American  
- [ ] Hispanic  
- [ ] Multiracial  
- [ ] Vietnamese  
- [ ] American Indian  
- [ ] Chinese  
- [ ] Hmong  
- [ ] Other Asian  
- [ ] White-Armenian  
- [ ] Asian Indian  
- [ ] Ethiopian  
- [ ] Japanese  
- [ ] Other Pacific Islander  
- [ ] White-Central American  
- [ ] Black/African-American  
- [ ] Filipino  
- [ ] Korean  
- [ ] Polynesian  
- [ ] White-European  
- [ ] Cambodian  
- [ ] Guamanian  
- [ ] Laotian  
- [ ] Samoan  
- [ ] White-Middle Eastern  
- [ ] Caribbean  
- [ ] Hawaiian  
- [ ] Mexican  
- [ ] South American  
- [ ] White-Romanian  
- [ ] Other

**Occupation:**  

**Education (last grade completed):**

**Employment/school status (check one):**
- [ ] Full-time  
- [ ] Part-time  
- [ ] Occasional  
- [ ] None

**Name of Employer/School attending:**

**Please check the problem area(s) which lead you to seek counseling at this time:**

<table>
<thead>
<tr>
<th>ADD/Learning Disability</th>
<th>Financial Problems</th>
<th>Separation Anxiety</th>
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</thead>
<tbody>
<tr>
<td>Alcohol or Drug Problems</td>
<td>Friendship Conflicts</td>
<td>Sexual Concerns</td>
</tr>
<tr>
<td>Angry/Hostile Feelings</td>
<td>General Anxiety</td>
<td>Sexual Harassment/Assault</td>
</tr>
<tr>
<td>Childhood Abuse</td>
<td>Grief-Related Concerns</td>
<td>Shyness</td>
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<tr>
<td>Communication Problems</td>
<td>Legal Problems</td>
<td>Sleeping Problems</td>
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<tr>
<td>Depression</td>
<td>Loneliness</td>
<td>Suicidal Feelings/Thoughts</td>
</tr>
<tr>
<td>Developmental Problems</td>
<td>Marital Problems</td>
<td>Test or Performance Anxiety</td>
</tr>
<tr>
<td>Disruptive Behavior Problems</td>
<td>Medical Concerns</td>
<td>Other:</td>
</tr>
<tr>
<td>Eating Problems/Disorder</td>
<td>Romantic Relationship Problems</td>
<td>Other:</td>
</tr>
<tr>
<td>Employment Problems</td>
<td>School Problems</td>
<td>Other:</td>
</tr>
<tr>
<td>Family Concerns</td>
<td>Self-Esteem/Self-Confidence</td>
<td>Other:</td>
</tr>
</tbody>
</table>

**FAMILY HISTORY:**

Please indicate which of the following is true for yourself or any other family members:

**Depression**
- [ ] Self  
- [ ] Mother  
- [ ] Father  
- [ ] Sibling  
- [ ] Grandparent

**Suicide Attempts**
- [ ] Self  
- [ ] Mother  
- [ ] Father  
- [ ] Sibling  
- [ ] Grandparent

**Alcohol Problems**
- [ ] Self  
- [ ] Mother  
- [ ] Father  
- [ ] Sibling  
- [ ] Grandparent

**Drug Problems**
- [ ] Self  
- [ ] Mother  
- [ ] Father  
- [ ] Sibling  
- [ ] Grandparent

**Anger/Violence**
- [ ] Self  
- [ ] Mother  
- [ ] Father  
- [ ] Sibling  
- [ ] Grandparent

**Mental/Emotional Problems**
- [ ] Self  
- [ ] Mother  
- [ ] Father  
- [ ] Sibling  
- [ ] Grandparent
### MEDICAL HISTORY:
Please check all of the following which you now have or have had in the past:

- Arthritis
- Asthma
- Back Problems
- Bedwetting/Soiling
- Diabetes
- Epilepsy/Convulsions
- Fainting/Dizziness
- Headaches (Frequent/Severe)
- Head Injury
- Heart problems
- High Blood Pressure
- Kidney Problems
- Mood Changes
- Other: ____________
- Other: ____________
- Shortness of Breath
- Sleep Difficulties
- Stomach Problems
- Stroke
- Unusual Bleeding
- Other: ____________

Are you now, or have you been under the care of a medical doctor during the past year?  
- YES  
- NO

Date of last examination: __________________________

Name/Address of Physician: __________________________

Are you now, or have you been under the care of a psychiatrist?  
- NOW  
- IN THE PAST  
- NEVER

If you are currently under the care of a psychiatrist: Name: __________________________

Address/City: __________________________ Telephone: (____)___________

List all medications you are now taking, both psychiatric and medical:

<table>
<thead>
<tr>
<th>Medication/Strength</th>
<th>Dosage per Day</th>
<th>Prescribed by</th>
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### MENTAL HEALTH HISTORY:
Have you consulted therapist/counselor of any type in the past?  
- YES  
- NO

If yes, please list (you may use the bottom of this form for additional space):

1. Name: __________________________ Address: __________________________ Dates of Service: __________
2. Name: __________________________ Address: __________________________ Dates of Service: __________

Have you been hospitalized for psychological/psychiatric reasons in the past?  
- YES  
- NO

If yes, please list (you may use the bottom of this form for additional space):

1. Name of Hospital: __________________________ City and State: __________________________ Dates of Hospitalization: __________
2. Name of Hospital: __________________________ City and State: __________________________ Dates of Hospitalization: __________

Have you ever attempted suicide in the past?  
- YES  
- NO

If yes, please describe below:

1. Approx. Date: __________ Method: __________ Did you tell anyone at the time?  
   - Yes  
   - No  
   Hospitalized as a result?  
   - Yes  
   - No
2. Approx. Date: __________ Method: __________ Did you tell anyone at the time?  
   - Yes  
   - No  
   Hospitalized as a result?  
   - Yes  
   - No
3. Approx. Date: __________ Method: __________ Did you tell anyone at the time?  
   - Yes  
   - No  
   Hospitalized as a result?  
   - Yes  
   - No

In case of an emergency, please contact:

Name: __________________________ Relationship to you: __________________________

Address: __________________________ Telephone: (____)___________
FRANCES SMITH CENTER FOR INDIVIDUAL AND FAMILY THERAPY
One University Drive
Orange, California 92866
(714) 997-6746

Susan Jester, M.A., LMFT
Director
Marriage & Family Therapist
License No. MFC31869
(714) 997-6904

AGREEMENT FOR SERVICE/INFORMED CONSENT
Welcome to Frances Smith Center for Individual and Family Therapy (hereinafter referred to as the “Center.”) Please read this information carefully as it outlines general information about the Center and its policies and procedures. If you have any questions, feel free to discuss them with your therapist.

Client’s Name: ___________________________ Voice Mail: (714) 744-7698, ext. ______

Therapist’s Name: ___________________________ Clinic Staff and Services:

I understand that the Center is a training facility staffed by therapists who are graduate students in the Department of Marriage and Family Therapy, Master of Arts program for Marriage and Family Therapy (Marriage and Family Therapist Trainee or “MFT Trainee”), under the supervision of licensed mental health professionals. The current supervisor’s name is Naveen Jonathan, Ph.D., LMFT, Licensed Marriage and Family Therapist, License No. MFC46703, telephone (714) 997-6932.

I further understand that as this is a training clinic, my therapist is NOT able to provide the following services: child custody evaluations, any court evaluations, workers compensation/disability evaluations, and any other type of evaluation which may require testifying in court. Therefore, I will let my therapist know immediately if I require these types of services so that appropriate outside referrals can be provided to me.

Statement of Confidentiality:
I understand that for the purposes of supervision, monitoring, and coordinating services, information I disclose may be communicated to Center staff and/or supervising clinicians on an as-needed basis. This information will be considered confidential and held to the standards of the psychotherapist-patient relationship.

I understand that no information may be revealed to anyone outside the Center without my written permission except where disclosure is required by law, including: (1) If I threaten suicide or physical harm to myself; (2) if I threaten homicide or physical harm to another person, including property; and/or (3) if there is a reasonable suspicion of child abuse or elder/dependent adult abuse. In addition, I understand that should I initiate a lawsuit against anyone, the other party’s right to mount the best defense may surpass my right to confidentiality, resulting in access to my psychotherapy records and/or requiring my therapist to appear in court. If I have any questions regarding any of the above information, I have been advised to ask my therapist.

Records and Recordkeeping:
I understand that my therapist may take notes during session, and will also produce other notes and records regarding my treatment. These notes constitute the Center’s clinical and business records, which by law, the therapist is required to maintain. Such records are the sole property of the Center. Should I request a copy of these records, I must make this request in writing. I understand that the Center will then provide me with a treatment summary in lieu of actual records. I also understand that the Center reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating healthcare provider. I understand that the Center will maintain my records for seven years following termination of therapy. However, after seven years, my records will be destroyed in a manner that preserves my confidentiality.

Risks and Benefits of Therapy:
I understand that psychotherapy is a process in which my therapist and I discuss a myriad of issues, events, experiences, and memories for the purpose of creating positive change so that I can experience my life more fully. It may result in a number of benefits to me, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require a substantial effort on my part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

I understand that participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings, and experiences, and evoke strong feelings of sadness, anger, fear, etc. There may be times...
that the therapist will challenge my perceptions and assumptions, and offer different perspectives. The issues that I present in therapy may result in unintended outcomes, including changes in personal relationships. I am aware that any decision on the status of my personal relationships is my responsibility. I understand that during the therapeutic process, I may feel worse before I feel better, which is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. I understand that I should address any concerns I have regarding my progress in therapy with my therapist.

**Clinical Assessment:**
In order to determine if the Center is an appropriate setting for me, I understand that my first few sessions will be considered an assessment period and my therapist will be gathering information from me and possibly from others that might be deemed to be helpful. This assessment may include my signing a release of information so that my therapist can obtain information about previous therapy or psychiatric hospitalizations, or to speak with my physician or psychiatrist. Or, my therapist may want me to undergo a medical or psychiatric evaluation as part of my assessment, or complete psychological testing. At the end of my assessment, I understand that my therapist will discuss with me what he/she feels would be most helpful to me. If it is determined that my needs exceed what the Center can provide, I understand that appropriate referrals will be provided to me.

**Emergencies, Voice Mail, and Appointments:**
I understand that I can leave a message for my therapist at any time on the voice mail system (number listed on page 1) and that my therapist will make every effort to return my call by the next business day. For maximum therapeutic effectiveness and to ensure confidentiality, telephone contacts are for arranging and changing appointment times and for emergencies only. In case of an emergency, I can call the exchange at (714) 997-6554, and an operator will assist in attempting to reach my therapist after hours. In the event that I am feeling unsafe or require immediate medical or psychiatric assistance, I should call 911 or go to the nearest emergency room. The Center does not utilize electronic mail (e-mail) for client contact. A standard psychotherapy session is 50 minutes. In the event I must cancel or reschedule a session, I agree to inform my therapist as soon as possible via voice mail. I further agree to notify my therapist at least 24 hours in advance when I need to cancel or reschedule an appointment. If I fail to do this, I agree to pay my regular fee for that session. I also understand that two (2) no shows/late cancellations or three (3) cancellations may result in termination of counseling, and I will be given a list of other low cost clinics as referrals.

**Payment and Fees:**
I understand that the Center operates on a strict cash or check basis, with a written receipt given for each payment. I further understand that it is expected that I will pay the full amount of the fee at the end of each session. If my check is returned for non-sufficient funds (“NSF”), I will be responsible for the session fee, plus a $25.00 “NSF” charge. This payment must be made in cash or money order to the Cashier’s Office. NOTE: Because the Center operates on a sliding scale, and because the therapists are MFT trainees, the Center is unable to accept insurance billing.

**Counseling Agreement:**
I understand that as a training facility, the Center requires observation and audio/video taping of counseling sessions. Persons authorized to view counseling through video monitors, one-way mirrors, or view video tapes are the Center Director, supervising clinicians, and counseling staff. All authorized persons who view therapy sessions are bound to maintain the confidentiality of the material discussed and to protect the identity of clients. I understand that should I not consent to observation and audio/video taping of my therapy session, I will be given referrals to other clinics in the area.

I hereby grant my permission for any psychotherapy, testing, observation, audio/video taping, or diagnostic evaluation that may be deemed pertinent by the Center. If it is determined that the Center is not the appropriate agency to meet my needs, I understand that I will be given referrals to resources more appropriate to my therapy needs and goals.

By my signature below, I certify that I have reviewed the information and I have been given the opportunity to ask questions and have them answered. I fully understand and agree to the information contained in this document, and that the information listed in this consent supersedes any previously signed forms. I have been given a copy of this document for my own records.

Dated:________________________20____

_____________________________
Signature of Client (or Parent/Guardian)

_____________________________
Signature of Therapist (MFT Trainee)

_____________________________
Signature of Center Director (1/2017)

Page 79 of 210
ANGER ASSESSMENT

CLIENT NAME: _______________________________  DATE: ______________

1. In client’s own words, why is anger a problem? __________________________

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

2. What was the most recent episode of anger? What were the circumstances?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

3. What was the most serious episode of anger?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

4. When angry, do you become physical?  □ YES  □ NO
If yes, describe: _______________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
5. What do others tell you about your anger? How have you been described?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

6. How often do you get angry? ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ OTHER

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

7. While growing up, how did members of your family show they were angry?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

8. Have you ever been in trouble legally due to your anger? ☐ YES ☐ NO
   If yes, describe: ____________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

9. OTHER INFORMATION THAT MAY BE RELEVANT: ____________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

DATED: ___________________________ ___________________________  

MFT Trainee
ATTENDANCE CONTRACT

Client Name: ______________________________

Therapist: ______________________________

I understand that for therapy to be effective, it is necessary that I attend sessions consistently on a weekly basis. When I don’t, the momentum for making change is lost and therapeutic progress is delayed.

This Attendance Contract is being established because my attendance has been as follows:

I have no-showed on the following dates: ______________________________

I have late cancelled on the following dates: ______________________________

I have cancelled on the following dates: ______________________________

As part of the Informed Consent that I signed in my first session, I agreed to the following:

“In the event I must cancel or reschedule a session, I agree to inform my therapist as soon as possible via voice mail. I further agree to notify my therapist at least 24 hours in advance when I need to cancel or reschedule an appointment. If I fail to do this, I agree to pay my regular fee for that session. I also understand that two (2) no shows/late cancellations or three (3) cancellations may result in termination of counseling, and I will be given a list of other low cost clinics as referrals.”

Therefore, I agree to attend my weekly scheduled appointments without any further cancellation, late cancellation, or no show. If I do not, I understand that I will no longer be eligible for services and I will be given referrals to other low cost clinics in the community.

Dated: ________________________________  Signature of Client/Parent/Guardian

Dated: ________________________________  Signature of Therapist

(/Attendance Contract)
AUTHORIZATION FOR MULTIPLE TREATMENT MODALITIES

**Rationale:** There are times when clients can best be served by treatment within multiple modalities, and times when this type of complexity will cause serious problems. For example, it might be best to treat adolescents with some combination of individual and family therapy carried out by two therapists working together. On the other hand, treating individuals who are also being seen in couples counseling simultaneously can potentially lead to problems including detouring of conflict, negative triangulation, or perceived breaches of confidentiality.

Therefore, adding modalities to existing cases should always be done: (1) With approval and oversight from the clinical supervisor; (2) With a clear rationale in mind (e.g., the client’s desire for additional therapy alone does not suffice); and (3) Only when multiple modalities are expected to be a clearly superior option to single modalities.

CLIENT NAME(S): ___________________________________________________________

THERAPIST: _______________________________________________________________

CLIENT IS CURRENTLY IN THE FOLLOWING MODALITY: ☐ Individual ☐ Couple ☐ Family

I AM REQUESTING TO ADD THE FOLLOWING MODALITY: ☐ Individual ☐ Couple ☐ Family

BRIEF SYSTEMIC CASE CONCEPTUALIZATION: ___________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

RATIONALE FOR MULTIPLE MODALITIES (describe the expected benefit): ____________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

PROVIDE A BRIEF EXPLANATION OF HOW YOU HAVE ATTEMPTED TO ADDRESS THIS ISSUE IN THE CURRENT MODALITY: __________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
COORDINATION OF TREATMENT PLAN (how will treating therapists coordinate their work, e.g., weekly meetings, co-therapy):

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

CLIENT(S) INFORMED OF FREE EXCHANGE OF INFORMATION AMONG TREATING THERAPISTS:

☐ YES  ☐ NO

IF "NO" EXPLAIN WHY NOT: ____________________________________________________________

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SUPERVISOR’S NOTE: I have reviewed this information and recommend the following:

☐ I agree with adding the new modality

☐ I disagree with adding the new modality for the following reason(s): ____________________________________________________________

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DATED: ________________________________ MFT Trainee

DATED: ________________________________ Clinical Supervisor

DATED: ________________________________ Clinic Director

Auth for Multiple Treatment Modalities.Rev
AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION

Client’s Name: ___________________________    Date of Birth: ___________________

Client may also be known as: ___________________________

I hereby authorize ___________________________, Marriage and Family Therapist Trainee at the Frances Smith Center for Individual and Family Therapy, to:

☐ Release information to:  ☐ Exchange information with:  ☐ Request information from:

Name of Person/Organization: __________________________________________

Address: __________________________________________________________________

Telephone Number: ___________________________    Fax Number: ___________________________

This authorization permits the release and/or exchange of the following information:

☐ Any and All Information Necessary    ☐ Treatment Plan    ☐ Mental Health Treatment
☐ Diagnosis    ☐ Clinical Test Results    ☐ Admission Summary
☐ Patient Records    ☐ Summary of Treatment    ☐ Discharge Summary
☐ Alcohol/Drug Treatment Information    ☐ Other: ___________________________

I authorize the release and/or exchange of the information described above for the following purposes:

Treatment planning

The recipient may use the information described above solely for the following purpose(s):

Coordination of care

Once the information has been sent to the individual or agency, by the power of this authorization, the responsibility for maintaining confidentiality for the released information is transferred.

I consent to the request/exchange of the above-specified information or records about my or my child’s condition and the treatment and services received to those persons or agencies listed. I further release Frances Smith Center for Individual and Family Therapy from any liabilities arising from the release of this information or records to such designated persons or agencies.

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This authorization shall remain valid until ___________________________ (“Expiration Date”). NOTE: If not specified, this release will be valid for one year from the date of the signature on this form.

By: ___________________________________________    Date: ________________

Signature of Client

By: ___________________________________________    Date: ________________

Signature of Client’s Parent/Guardian/Representative    (Rev. Aug 2014)

*If signed by other than client, please indicate the relationship between client and his/her Representative.
CAPSTONE PROJECT

As part of the graduation requirements, MFT students are required to complete a Capstone Project in their final semester in the MFT Program. The Capstone Project will include three parts, A). a theory of change paper, B). a comprehensive written case report and C). an oral case presentation, which includes a videotape demonstrating specific interventions.

A). Theory of Change Paper

Students will start writing this paper in MFT 556 and continue to develop it during the three semesters of practicum in the Frances Smith Center. The students can decide to change their Theory of Change at any point. If they decide to do so, at that point they would have to rewrite the paper based on their new Theory of Change. The students will submit the Theory of Change paper to their group supervisor in their first semester in the Frances Smith Center after making revisions based on the feedback they received in MFT 556 as well as more in-depth study of their Theory of Change. They would then submit a revised version of this paper to their group supervisor in the second semester in the Frances Smith Center. They would be expected to revise the paper based on the feedback they receive from their supervisor in the first semester and based on more in-depth study of their Theory of Change. Along with this revised version they would also be expected to submit a hard copy of the paper from the previous semester for which they had received feedback from the previous supervisor. In the final semester in the Frances Smith Center they would submit the final version of their Theory of Change paper after making further revisions based on the feedback they received in MFT 556 and the previous two semesters as well as further in-depth study. Along with this revised version they would also be expected to submit a hard copy of the paper from the previous two semesters for which they had received feedback from the previous supervisor(s). This paper should be written in APA format and the final version should be about 30 pages. The paper should include at least 30 references which must be either articles from peer reviewed journals or original sources including books. This paper will be due two weeks prior to the Oral Case Presentation.

The format of the Theory of Change Paper will be as follows:

1. Biographical information:
   • What aspects of your background have contributed to your uniqueness?
   • What events and patterns in your life have influenced your theory of therapy?
   • What was the impact of major life figures on the development of your personal beliefs about people?
   • What client populations do you believe you would be most effective and least effective in working with?

2. What are the major concepts of your theory of change?

3. What is the difference between healthy and dysfunctional families according to your theory of change?

4. How could change be anticipated to occur based on your theory of change?

5. Stance of therapist
   • What therapist and client characteristics promote change?
• What is the role of the therapist according to your theory of change?
6. What areas would your assessment focus on given your theory of change?
7. What type of goals would you want for your therapy sessions?
8. What techniques/interventions would you use to facilitate changes in your clients?
9. How would you know that your client is ready for termination?
10. How would you address diversity related issues with your clients using your theory of change?
11. What types of clients/problems is your theory of change most likely to be effective for?

The grading rubric for the Theory of Change Paper (part of Capstone Project) can be found in Appendix___. The Theory of Change Paper Evaluation Form can be found in Appendix___. The grading rubric for the Theory of Change Paper (first and second semester in the Frances Smith Center) can be found in Appendix___.

B). Comprehensive Written Case Report
During their training at the Frances Smith Center the students will select a case based on which they will write a Comprehensive Written Case Report as part of the Capstone Project. The case should be relational in nature (couple/family/parent-child unit etc.). Cases in which individuals are the unit of treatment cannot be selected for case presentations for the Capstone Project. The student should have had at least four sessions with the client before they submit the Comprehensive Written Case Report.

The Comprehensive Written Case Report will be submitted to the group supervisor during the final semester at the Frances Smith Center along with the final version of the Theory of Change Paper. The student will be expected to prepare a three-generation genogram of the couple/family they are writing the case report on. The case report will be based on the following format:

1. **Identifying information and clinical data** (age, gender, ethnicity, family composition, occupation and/or school status, relationship status, SES, treatment history, clinical symptoms, presenting problems, medications, history of mental illness or family dysfunction, significant medical problems, why client is seeking treatment).

2. **Systemic assessment and clinical assessment**, utilizing the genogram (include significant family patterns and events, chemical dependency, others living in the home, medical problems, intergenerational issues). If treating a couple, include information about their relationship history.

3. **DSM-5 Diagnosis**, listed by number and providing rationale for client’s diagnosis, including symptoms and client’s report of symptoms. If appropriate, provide a differential process. Do not forget to diagnose each client you are treating in the treatment unit.
4. **Theoretical model of treatment**, used to conceptualize the case, develop the treatment plan and intervene.

5. **Case Conceptualization**, which is a tentative explanation of the ways in which relational patterns are operating to keep a family from, and move a family toward optimum functioning. Case conceptualizations are dynamic and should evolve over time as the case progresses. Your case conceptualization should be derived from *on-going* clinical assessment that is informed by systems theory in general and MFT clinical theories and models in particular.

6. **Treatment objectives/goals**, develop a complete treatment plan and prioritize treatment goals based on assessment, diagnosis, and chosen theoretical model. Treatment plan should be consistent with a theoretical model and should be broken down into a beginning, middle and closing phase.

7. **Brief summary of how change could be anticipated** to occur for this individual/couple/family (within the theoretical model)

8. **Description of the role of the therapist** within the theoretical model

9. **Research-based interventions** and techniques that have been used and will be used. Therapeutic interventions should be presented consistent with the chosen theory. This section should include a discussion of client’s motivation for treatment, specific interventions implemented, including rationale, expected outcome, and potential barriers to treatment. The interventions should be informed by research and the case report should demonstrate that through citations. If relevant, describe how crisis issues were managed. Also discuss the implementation and management of safety plans if applicable.

10. An assessment of possible **transference and counter transference considerations**

11. A discussion of possible **ethical/legal** considerations and how they would be addressed. Include a discussion of the identification and management of any legal/ethical obligations and mandates that apply specifically to the case.

12. Discuss any **diversity** (including but not limited to race, age, gender, ethnicity, sexual orientation, gender identity, socioeconomic status, disability, health status, religious, spiritual and/or political beliefs, nation of origin or other relevant social categories, immigration or language) considerations and how they may impact treatment. Include discussion on marginalized and/or underserved communities when applicable.
The discussion should focus on:

i. **Cultural identity** (ethnic/cultural reference). Cultural identity should be explored for all clients and not just minority clients. For immigrants and ethnic minorities, note the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use and preference (including multilingualism).

ii. **Cultural factors related to psychosocial environment and levels of functioning**: Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

iii. **Diversity elements of the relationship between the individual and the clinician**: Indicate differences in diversity related factors between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual’s first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).

iv. **Overall assessment of diversity related factors for diagnosis and care**: The formulation concludes with a discussion of how diversity considerations specifically influence comprehensive diagnosis and care.

13. **Case management** considerations (consents and initial structuring of treatment, who attends sessions, managing family secrets, missed appointments, crisis management, referrals, termination, etc.)

14. **Client-centered advocacy (CCA)** (any adjunctive services that would be important to meeting treatment goals including referrals, telephone conversations, and other CCA-related activities)

15. **Evaluation of the therapeutic process to date**, including an assessment of the therapeutic relationship

The grading guidelines for the Comprehensive Written Case Report can be found in Appendix___. The Comprehensive Written Case Report Evaluation Form can be found in Appendix___.

**C. Oral Case Presentation**
During the time allocated for group supervision all graduating students will make an Oral Case Presentation around midterm time in their final semester in the Frances Smith
Center as part of their Capstone Project. The Oral Case Presentation will be based on the case that is selected for the Comprehensive Written Case Report and will follow the same format as the Comprehensive Written Case Report. The presentation should not take more than 60 minutes following which 20 minutes will be for questions from the supervisor and 20 minutes for discussion which will make a total of 1 hour 40 minutes. The Oral Case Presentation should be accompanied by a Power Point which should be submitted to the group supervisor 1 week prior to the Oral Case Presentation. The Oral Case Presentation should include four videotape clips from sessions with the client(s). The clips should be from sessions from different phases of treatment including early, middle and current phase.

The same grading guidelines will be used for both the Comprehensive Written Case Report and the Oral Case Presentation. This grading guide can be found in Appendix ___. The Oral Case Presentation Evaluation Form can be found in Appendix ___. Some questions that the supervisor could ask after the Oral Case Presentation can be found in Appendix ___.

Grading for the Capstone Project
In order to overall pass the Capstone Project the student must pass all three components of the Capstone Project which include the:
A). Theory of Change Paper
B). Comprehensive Written Case Report and
C). Oral Case Presentation

Passing the Capstone Project
In order to pass the Capstone Project the student should get a “meets or exceeds expectations” on all the sections of the Theory of Change Paper. The student should also get a “meets or exceeds expectations” on all sections of the Comprehensive Written Case Report as well as the Oral Case Presentation.

Passing the Capstone Project with Recommendations
If the student gets a “below expectations” on any section of the Theory of Change Paper, Comprehensive Written Case Report or the Oral Case Presentation the student will pass with recommendations. The recommendation will be provided by the group supervisor and the student will have to show proof of completion before graduation.

Failing the Capstone Project
If the student gets a “deficient” on any section of the Theory of Change Paper, Comprehensive Written Case Report or the Oral Case Presentation the student will fail the Capstone Project. The group supervisor will provide the student with stipulations in consultation with the Clinic Director and the Program Director. The student will have to show proof of completion of the stipulations in order to graduate. The Final Evaluation Form for the Capstone Project can be found in Appendix ___.

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### Capstone Project

#### Grading Rubric: Theory of Change Paper

<table>
<thead>
<tr>
<th>Component</th>
<th>Exceptional Skills (3 points)</th>
<th>Exceeds Expectations (3 points)</th>
<th>Meets Expectations (3 points)</th>
<th>Below Expectations (2 points)</th>
<th>Deficient (1 point)</th>
<th>Inadequate Information (0 points)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Biographical Information</strong></td>
<td>All sub-components are clearly and coherently addressed and connection to theory of change is sophisticatedly established</td>
<td>All sub-components are clearly and coherently addressed and connection to theory of change is skillfully established</td>
<td>All sub-components are clearly and coherently addressed and connection to theory of change is well established</td>
<td>Some sub-components are inadequately addressed and connection to theory of change is not well established</td>
<td>Some sub-components are inadequately addressed and connection to theory of change is not established</td>
<td>Unable to assess due to lack of adequate information</td>
</tr>
<tr>
<td><strong>Major Concepts</strong></td>
<td>All major concepts are included and accurately and sophisticatedly described</td>
<td>Adequately, clearly and skillfully described using the language of the theory</td>
<td>Adequately and clearly described using the language of the theory</td>
<td>Partially and not clearly described without using language of the theory</td>
<td>Difference is not described</td>
<td>A few major concepts are included and inaccurately described</td>
</tr>
<tr>
<td><strong>Difference between healthy and dysfunctional families</strong></td>
<td>Adequately, clearly and skillfully described using the language of the theory</td>
<td>Adequately, clearly and skillfully described using the language of the theory</td>
<td>Adequately and clearly described using the language of the theory</td>
<td>Partially and not clearly described without using language of the theory</td>
<td>Partially and not clearly described without using language of the theory</td>
<td>Partially and not clearly described without using language of the theory</td>
</tr>
<tr>
<td><strong>How change anticipated</strong></td>
<td>Adequately, clearly and skillfully described using the language of the theory</td>
<td>Adequately, clearly and skillfully described using the language of the theory</td>
<td>Adequately and clearly described using the language of the theory</td>
<td>Partially and not clearly described without using language of the theory</td>
<td>Partially and not clearly described without using language of the theory</td>
<td>How change anticipated not described</td>
</tr>
<tr>
<td><strong>Stance of therapist</strong></td>
<td>Adequately, clearly and skillfully described using the language of the theory</td>
<td>Adequately, clearly and skillfully described using the language of the theory</td>
<td>Adequately and clearly described using the language of the theory</td>
<td>Partially and not clearly described without using language of the theory</td>
<td>Partially and not clearly described without using language of the theory</td>
<td>Stance of therapist not described</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td>Adequately, clearly and skillfully described using the language of the theory</td>
<td>Adequately, clearly and skillfully described using the language of the theory</td>
<td>Adequately and clearly described using the language of the theory</td>
<td>Partially and not clearly described without using language of the theory</td>
<td>Partially and not clearly described without using language of the theory</td>
<td>Areas of assessment not described</td>
</tr>
<tr>
<td><strong>Treatment Goals</strong></td>
<td>Adequately, clearly and sophisticatedly stated using the language of the theory</td>
<td>Adequate, clearly and skillfully stated using the language of the theory</td>
<td>Adequate and clearly stated using the language of the theory</td>
<td>Inadequate, not clearly stated but use the language of the theory</td>
<td>Inadequate, not clearly stated and do not use the language of the theory</td>
<td>Goals not stated</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Interventions</strong></td>
<td>Research informed, adequately, clearly and skillfully described using the language of the theory</td>
<td>Research informed, adequately and clearly described using the language of the theory</td>
<td>Research informed, partially and clearly described using the language of the theory</td>
<td>Not research informed, partially and not clearly described without using language of the theory</td>
<td>Interventions not described</td>
<td></td>
</tr>
<tr>
<td><strong>Termination</strong></td>
<td>Readiness for termination adequately, clearly and skillfully described</td>
<td>Readiness for termination adequately and clearly described</td>
<td>Readiness for termination inadequately but clearly described</td>
<td>Readiness for termination inadequately and not clearly described</td>
<td>Readiness for termination not described</td>
<td></td>
</tr>
<tr>
<td><strong>Diversity</strong></td>
<td>How these issues will be addressed adequately, clearly and skillfully described</td>
<td>How these issues will be addressed adequately, clearly and skillfully described</td>
<td>How these issues will be addressed inadequately but clearly described</td>
<td>How these issues will be addressed inadequately and not clearly described</td>
<td>How these issues will be addressed not described</td>
<td></td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
<td>Types of clients/problems supported by research and clearly and skillfully described</td>
<td>Types of clients/problems supported by research and clearly described</td>
<td>Types of clients/problems supported by research but not clearly described</td>
<td>Types of clients/problems not supported by research and not clearly described</td>
<td>Types of clients/problems theory of change will be effective for not described</td>
<td></td>
</tr>
</tbody>
</table>
Capstone Project: Theory of Change Paper Evaluation Form

Student’s Name__________________________   Date____________________

Please evaluate the student according to the following grading criteria:
   Deficient - 1, Below Expectations - 2, Meets Expectations - 3, Exceeds Expectations - 3,
   Exceptional Skills – 3

1. Biographical Information

Please circle the appropriate number based on the student’s performance:
Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:

2. Major Concepts

Please circle the appropriate number based on the student’s performance:
Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:

3. Difference Between Healthy and Dysfunctional Families

Please circle the appropriate number based on the student’s performance:
Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:

4. How Change Anticipated

Please circle the appropriate number based on the student’s performance:
Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:
5. Stance of Therapist

Please circle the appropriate number based on the student's performance:
Deficient – 1, Below Expectations – 2, Meets Expectations – 3, Exceeds Expectations – 3, Exceptional Skills – 3

Narrative Comments:

6. Assessment

Please circle the appropriate number based on the student's performance:
Deficient – 1, Below Expectations – 2, Meets Expectations – 3, Exceeds Expectations – 3, Exceptional Skills – 3

Narrative Comments:

7. Treatment Goals

Please circle the appropriate number based on the student's performance:
Deficient – 1, Below Expectations – 2, Meets Expectations – 3, Exceeds Expectations – 3, Exceptional Skills – 3

Narrative Comments:

8. Interventions

Please circle the appropriate number based on the student's performance:
Deficient – 1, Below Expectations – 2, Meets Expectations – 3, Exceeds Expectations – 3, Exceptional Skills – 3

Narrative Comments:

9. Termination

Please circle the appropriate number based on the student's performance:
Deficient – 1, Below Expectations – 2, Meets Expectations – 3, Exceeds Expectations – 3, Exceptional Skills – 3

Narrative Comments:
10. Diversity

Please circle the appropriate number based on the student's performance:

Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:

11. Effectiveness

Please circle the appropriate number based on the student's performance:

Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:

Decision:

____ Passed
____ Passed with Recommendations
____ Failed with stipulations

_______________________________  ________________________________
Supervisor's Signature    Supervisor’s Printed Name
<table>
<thead>
<tr>
<th>Content (10 points)</th>
<th>Revisions (2 points)</th>
<th>Organization and Coherence (2 points)</th>
<th>Style (1 point)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each of the 11 sections of the paper are adequately discussed.</td>
<td>-Revisions based on the feedback provided by previous supervisor(s) have been made.</td>
<td>-Uses logical structure</td>
<td>- APA formatted</td>
</tr>
<tr>
<td></td>
<td>-Revisions based on new research/developments in the theory have been made.</td>
<td>-Clearly organized</td>
<td>-Fully cited and referenced</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Makes meaningful connections</td>
<td>- Almost entirely free of spelling, punctuation, and grammatical errors (or only 1-2 minor)</td>
</tr>
</tbody>
</table>
### Grading Guide: Comprehensive Written Case Report and Oral Case Presentation

#### 1. Identifying Info/Genogram

**Identifying information and clinical data** (age, gender, ethnicity, family composition, occupation and/or school status, relationship status, SES, treatment history, clinical symptoms, presenting problems, medications, history of mental illness or family dysfunction, significant medical problems, why client is seeking treatment).

Deficient=1, Below Expectations=2, Meets Expectations=3, Exceeds Expectations=3, Exceptional Skills=3

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEFICIENT</strong></td>
<td>The therapist gathered insufficient information.</td>
</tr>
<tr>
<td></td>
<td>- The presenting problem was not clearly identified.</td>
</tr>
<tr>
<td></td>
<td>- The therapist did not collect information to assess clinical issues.</td>
</tr>
<tr>
<td></td>
<td>- The therapist made clinical interpretations that are not relevant to the</td>
</tr>
<tr>
<td></td>
<td>case.</td>
</tr>
<tr>
<td></td>
<td>- The three generation genogram was not provided.</td>
</tr>
<tr>
<td><strong>BELOW EXPECTATIONS</strong></td>
<td>The therapist gathered superficial information</td>
</tr>
<tr>
<td></td>
<td>- The therapist did not collect enough information to assess clinical issues.</td>
</tr>
<tr>
<td></td>
<td>- The three generation genogram was incomplete.</td>
</tr>
<tr>
<td><strong>MEETS EXPECTATIONS</strong></td>
<td>The therapist gathered and integrated essential information.</td>
</tr>
<tr>
<td></td>
<td>- The therapist gathered and integrated all essential information to the</td>
</tr>
<tr>
<td></td>
<td>case.</td>
</tr>
<tr>
<td></td>
<td>- The therapist supported their clinical interpretations which were relevant</td>
</tr>
<tr>
<td></td>
<td>to the case.</td>
</tr>
<tr>
<td></td>
<td>- The three generation genogram was complete.</td>
</tr>
<tr>
<td><strong>EXCEEDS EXPECTATIONS</strong></td>
<td>The therapist skillfully gathered and integrated essential information.</td>
</tr>
<tr>
<td></td>
<td>- The therapist skillfully gathered and integrated all essential information</td>
</tr>
<tr>
<td></td>
<td>to the case.</td>
</tr>
<tr>
<td></td>
<td>- The three generation genogram was complete.</td>
</tr>
<tr>
<td><strong>EXCEPTIONAL SKILLS</strong></td>
<td>The therapist sophisticatedly gathered and integrated essential information.</td>
</tr>
<tr>
<td></td>
<td>- The therapist sophisticatedly gathered and integrated all essential</td>
</tr>
<tr>
<td></td>
<td>information to the case.</td>
</tr>
<tr>
<td></td>
<td>- The three generation genogram was complete.</td>
</tr>
</tbody>
</table>
2. Systemic Assessment

**Systemic assessment and clinical assessment**, utilizing the genogram (include significant family patterns and events, chemical dependency, others living in the home, medical problems, intergenerational issues). If treating a couple, include information about their relationship history.

<table>
<thead>
<tr>
<th>Deficient=1, Below Expectations=2, Meets Expectations=3, Exceeds Expectations=3, Exceptional Skills=3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEFICIENT</strong></td>
</tr>
<tr>
<td>The therapist did not consider the case from a systemic perspective.</td>
</tr>
<tr>
<td>- The therapist did not provide a systemic assessment of the presenting problem.</td>
</tr>
<tr>
<td>- The three generation genogram was not provided.</td>
</tr>
<tr>
<td>- The therapist did not administer tests to support their diagnosis and clinical impressions.</td>
</tr>
<tr>
<td><strong>BELOW EXPECTATIONS</strong></td>
</tr>
<tr>
<td>The therapist superficially considered the case from a systemic perspective.</td>
</tr>
<tr>
<td>- The therapist provided a poor systemic assessment of the presenting problem.</td>
</tr>
<tr>
<td>- The therapist did not integrate information from the genogram into their assessment.</td>
</tr>
<tr>
<td>- The therapist administered inappropriate tests to support their diagnosis and clinical impressions.</td>
</tr>
<tr>
<td><strong>MEETS EXPECTATIONS</strong></td>
</tr>
<tr>
<td>The therapist demonstrated a systemic understanding of the case and the clinical implications for treatment.</td>
</tr>
<tr>
<td>- The therapist provided a systemic assessment of the presenting problem.</td>
</tr>
<tr>
<td>- The therapist integrated information from the genogram into their assessment.</td>
</tr>
<tr>
<td>- The therapist administered and interpreted appropriate test results to support their diagnosis and clinical impressions.</td>
</tr>
<tr>
<td><strong>EXCEEDS EXPECTATIONS</strong></td>
</tr>
<tr>
<td>The therapist demonstrated a skilled systemic understanding of the case and the clinical implications for treatment.</td>
</tr>
<tr>
<td>- The therapist provided a skilled systemic assessment of the presenting problem.</td>
</tr>
<tr>
<td>- The therapist skillfully integrated information from the genogram into their assessment</td>
</tr>
<tr>
<td>- The therapist administered and skillfully interpreted appropriate test results to support their diagnosis and clinical impressions.</td>
</tr>
<tr>
<td><strong>EXCEPTIONAL SKILLS</strong></td>
</tr>
<tr>
<td>The therapist demonstrated a sophisticated systemic understanding of the case and the clinical implications for treatment.</td>
</tr>
<tr>
<td>- The therapist provided a sophisticated systemic assessment of the presenting problem.</td>
</tr>
<tr>
<td>- The therapist integrated information from the genogram into their assessment in a sophisticated manner.</td>
</tr>
<tr>
<td>- The therapist administered and interpreted appropriate test results to support their diagnosis and clinical impressions in a sophisticated manner.</td>
</tr>
</tbody>
</table>
3. Diagnosis

**DSM-5 Diagnosis**, listed by number and providing rationale for client’s diagnosis, including symptoms and client’s report of symptoms. If appropriate, provide a differential process. Do not forget to diagnose each client you are treating in the treatment unit.

Deficient=1, Below Expectations=2, Meets Expectations=3, Exceeds Expectations=3, Exceptional Skills=3

<table>
<thead>
<tr>
<th>Deficient</th>
<th>The diagnosis is incomplete and/or incorrect.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The therapist did not collect information to formulate an accurate diagnostic impression.</td>
</tr>
<tr>
<td></td>
<td>• The therapist did not diagnose each client in the treatment unit.</td>
</tr>
<tr>
<td>Below Expectations</td>
<td>The therapist formed a diagnostic impression without sufficient support.</td>
</tr>
<tr>
<td></td>
<td>• The therapist gathered insufficient information to formulate a diagnostic impression.</td>
</tr>
<tr>
<td></td>
<td>• The therapist formed a diagnostic impression without sufficient support.</td>
</tr>
<tr>
<td></td>
<td>• The therapist formulated a diagnostic impression without considering relational and contextual aspects.</td>
</tr>
<tr>
<td></td>
<td>• The therapist did not diagnose each client in the treatment unit.</td>
</tr>
<tr>
<td>Meets Expectations</td>
<td>The therapist formulated an accurate diagnostic impression.</td>
</tr>
<tr>
<td></td>
<td>• The therapist formed a diagnostic impression with sufficient support.</td>
</tr>
<tr>
<td></td>
<td>• The therapist formulated a diagnostic impression taking relational and contextual aspects into consideration.</td>
</tr>
<tr>
<td></td>
<td>• The therapist diagnosed each client in the treatment unit.</td>
</tr>
<tr>
<td>Exceeds Expectations</td>
<td>The therapist gathered and integrated essential information and diagnosed accurately.</td>
</tr>
<tr>
<td></td>
<td>• The therapist formed a diagnostic impression with sufficient support.</td>
</tr>
<tr>
<td></td>
<td>• The therapist formulated a diagnostic impression taking relational and contextual aspects into consideration.</td>
</tr>
<tr>
<td></td>
<td>• The therapist administered and interpreted test results to support their diagnosis and clinical impressions.</td>
</tr>
<tr>
<td></td>
<td>• The therapist diagnosed each client in the treatment unit.</td>
</tr>
<tr>
<td>Exceptional Skills</td>
<td>The therapist sophisticatedly gathered and integrated essential information and diagnosed accurately.</td>
</tr>
<tr>
<td></td>
<td>• The therapist formed a diagnostic impression with sufficient support.</td>
</tr>
<tr>
<td></td>
<td>• The therapist formulated a diagnostic impression taking relational and contextual aspects into consideration.</td>
</tr>
<tr>
<td></td>
<td>• The therapist administered and interpreted test results to support their diagnosis and clinical impressions.</td>
</tr>
<tr>
<td></td>
<td>• The therapist used several assessment methods to support their diagnosis.</td>
</tr>
<tr>
<td></td>
<td>• The therapist diagnosed each client in the treatment unit.</td>
</tr>
</tbody>
</table>
4. Case Conceptualization

**Case Conceptualization**, which is a tentative explanation of the ways in which relational patterns are operating to keep a family from, and move a family toward optimum functioning. Case conceptualizations are dynamic and should evolve over time as the case progresses. Your case conceptualization should be derived from on-going clinical assessment that is informed by systems theory in general and MFT clinical theories and models in particular.

Deficient=1, Below Expectations=2, Meets Expectations=3, Exceeds Expectations=3, Exceptional Skills=3

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEFICIENT</strong></td>
<td>The therapist did not provide a systemic case conceptualization</td>
</tr>
<tr>
<td><strong>BELOW EXPECTATIONS</strong></td>
<td>The therapist provided a superficial case conceptualization which was not systemic.</td>
</tr>
<tr>
<td></td>
<td>- The therapist demonstrated a poor understanding of the case and the clinical implications for treatment.</td>
</tr>
<tr>
<td></td>
<td>- The case conceptualization was not derived from on-going clinical assessment.</td>
</tr>
<tr>
<td><strong>MEETS EXPECTATIONS</strong></td>
<td>The therapist demonstrated the ability to formulate a systemic case conceptualization.</td>
</tr>
<tr>
<td></td>
<td>- The therapist demonstrated an understanding of the case and the clinical implications for treatment.</td>
</tr>
<tr>
<td></td>
<td>- The case conceptualization was derived from on-going clinical assessment.</td>
</tr>
<tr>
<td><strong>EXCEEDS EXPECTATIONS</strong></td>
<td>The therapist demonstrated the ability to skillfully formulate a systemic case conceptualization.</td>
</tr>
<tr>
<td></td>
<td>- The therapist demonstrated a skilled understanding of the case and the clinical implications for treatment.</td>
</tr>
<tr>
<td></td>
<td>- The case conceptualization was derived from on-going clinical assessment.</td>
</tr>
<tr>
<td><strong>EXCEPTIONAL SKILLS</strong></td>
<td>The therapist demonstrated the ability to formulate an exceptional systemic case conceptualization.</td>
</tr>
<tr>
<td></td>
<td>- The therapist demonstrated a sophisticated understanding of the case and the clinical implications for treatment.</td>
</tr>
<tr>
<td></td>
<td>- The case conceptualization was derived from on-going clinical assessment.</td>
</tr>
</tbody>
</table>
5. Theoretical Model

The theoretical model of treatment, used to conceptualize the case, develop the treatment plan and intervene.

<table>
<thead>
<tr>
<th>Deficient=1, Below Expectations=2, Meets Expectations=3, Exceeds Expectations=3, Exceptional Skills=3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEFICIENT</strong></td>
</tr>
</tbody>
</table>
| **BELOW EXPECTATIONS** | The therapist did not clearly identify a theoretical model of treatment or applied it in an inconsistent manner.  
  - The therapist did not match the treatment model to the client’s needs and treatment goals. |
| **MEETS EXPECTATIONS** | The therapist sufficiently articulated a specific theoretical model of treatment.  
  - The therapist matched the treatment model to the client’s needs and treatment goals. |
| **EXCEEDS EXPECTATIONS** | The therapist skillfully articulated a specific theoretical model of treatment.  
  - The therapist matched the treatment model to the client’s needs and treatment goals. |
| **EXCEPTIONAL SKILLS** | The therapist sophisticatedly articulated a specific theoretical model of treatment.  
  - The therapist matched the treatment model to the client’s needs and treatment goals. |

6. Treatment Goals

Treatment objectives/goals, develop a complete treatment plan and prioritize treatment goals based on assessment, diagnosis, and chosen theoretical model. Treatment plan should be consistent with a theoretical model and should be broken down into a beginning, middle and closing phase.

<table>
<thead>
<tr>
<th>Deficient=1, Below Expectations=2, Meets Expectations=3, Exceeds Expectations=3, Exceptional Skills=3</th>
</tr>
</thead>
</table>
| **DEFICIENT** | The therapist did not create a plan for treatment.  
  - The therapist did not identify barriers to treatment.  
  - The therapist did not identify or discuss phases of treatment. |
| **BELOW EXPECTATIONS** | The therapist created a treatment plan which was incomplete.  
  - The therapist provided superficial or incomplete information about the beginning, middle, and closing phases of treatment.  
  - The treatment plan was not consistent with the theoretical model of treatment. |
| **MEETS EXPECTATIONS** | The therapist provided a treatment plan appropriate for the diagnosis.  
  - The therapist provided a treatment plan and/or techniques that are appropriate for the client’s diagnosis.  
  - The treatment plan was consistent with the theoretical model of treatment. |
The therapist developed, with the client’s input, treatment goals and measurable outcomes utilizing a systemic perspective.

The therapist identified appropriate goals and interventions for the beginning, middle, and closing phases of treatment.

**EXCEEDS EXPECTATIONS**
The therapist skillfully utilized a treatment plan appropriate for the diagnosis.

- The therapist provided a treatment plan and/or techniques that are appropriate for the client’s diagnosis.
- The treatment plan was consistent with the theoretical model of treatment.
- The therapist developed, with the client’s input, treatment goals and measurable outcomes utilizing a systemic perspective.
- The therapist identified appropriate goals and interventions for the beginning, middle, and closing phases of treatment.
- The therapist recognized when treatment goals and interventions needed to be modified and made the necessary modifications.

**EXCEPTIONAL SKILLS**
The therapist provided an exceptional treatment plan appropriate for the diagnosis.

- The therapist provided a treatment plan and/or techniques that are appropriate for the client’s diagnosis.
- The treatment plan was consistent with the theoretical model of treatment.
- The therapist developed, with the client’s input, treatment goals and measurable outcomes utilizing a systemic perspective.
- The therapist identified appropriate goals and interventions for the beginning, middle, and closing phases of treatment.
- The therapist recognized when treatment goals and interventions needed to be modified and made the necessary modifications.
- The therapist discussed potential limitations of the chosen model of therapy and provided an alternative approach to therapy.
- The therapist provided a rationale for assessment and re-evaluation of the treatment plan.

**7. Theory of Change**

**Brief summary of how change could be anticipated** to occur for this individual/couple/family (within the theoretical model)

Deficient=1, Below Expectations=2, Meets Expectations=3, Exceeds Expectations=3, Exceptional Skills=3

**DEFICIENT**
The therapist did not provide a theory of change based on the chosen theoretical model.

**BELOW EXPECTATIONS**
The therapist demonstrated a poor understanding of the theory of change based on the chosen theoretical model.

**MEETS EXPECTATIONS**
The therapist demonstrated the ability to clearly articulate the theory of change based on the chosen theoretical model.
The therapist demonstrated the ability to clearly and skillfully articulate the theory of change based on the chosen theoretical model.

The therapist demonstrated the ability to clearly and sophisticatedly articulate the theory of change based on the chosen theoretical model.

### 8. Role of Therapist

**Description of the role of the therapist** within the theoretical model

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<thead>
<tr>
<th>Deficient=1, Below Expectations=2, Meets Expectations=3, Exceeds Expectations=3, Exceptional Skills=3</th>
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<tbody>
<tr>
<td><strong>DEFICIENT</strong></td>
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<tr>
<td><strong>BELOW EXPECTATIONS</strong></td>
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<tr>
<td><strong>MEETS EXPECTATIONS</strong></td>
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<tr>
<td><strong>EXCEEDS EXPECTATIONS</strong></td>
</tr>
<tr>
<td><strong>EXCEPTIONAL SKILLS</strong></td>
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</table>

### 9. Research-Based Interventions

**Specific interventions** and techniques that have been used and will be used. Therapeutic interventions should be presented consistent with the chosen theory. This section should include a discussion of client’s motivation for treatment, specific interventions implemented, including rationale, expected outcome, and potential barriers to treatment. The interventions should be informed by research and the case report should demonstrate that through citations. If relevant, describe how crisis issues were managed. Also discuss the implementation and management of safety plans if applicable.

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<thead>
<tr>
<th>Deficient=1, Below Expectations=2, Meets Expectations=3, Exceeds Expectations=3, Exceptional Skills=3</th>
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<tr>
<td><strong>DEFICIENT</strong></td>
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<tr>
<td>• The therapist applied interventions that put the client in danger.</td>
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<tr>
<td>• The therapist used interventions without consideration of the presenting problem.</td>
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<tr>
<td><strong>BELOW EXPECTATIONS</strong></td>
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</table>
- The therapist implemented interventions based on theoretical bias rather than on the client’s needs.
- The therapist applied interventions that were insensitive to the client’s needs.

**MEETS EXPECTATIONS**
The therapist used sufficient intervention(s) that were theory and client specific and consistently fit with the treatment goals. The therapist provided a description of the intervention(s).
- The therapist was able to deliver and revise intervention(s) in a way that was sensitive to the client’s needs.
- The therapist recognized how the techniques may impact the therapeutic process.
- The therapist was able to utilize systemic interventions that were research based.
- The therapist was able to provide psychoeducational material that was appropriate for the client.

**EXCEEDS EXPECTATIONS**
The therapist used skilled intervention(s) that were theory and client specific and supported goal achievement. The therapist included several descriptions of the interventions from each stage of treatment.
- The therapist was able to effectively engage the family in the treatment process.
- The therapist was able to adjust the treatment goals according to the client’s progress in therapy.
- The therapist was able to skillfully utilize systemic interventions that were research based.
- The therapist was able to integrate their supervisor’s feedback into treatment.
- The therapist was able to present rationale for the interventions.

**EXCEPTIONAL SKILLS**
The therapist used sophisticated intervention(s) that were theory and client specific and strongly supported goal achievement. The therapist included several specific descriptions of interventions from each stage of treatment.
- The therapist was able to evaluate their own ability to deliver the interventions.
- The therapist was able to sophisticatedly utilize systemic interventions that were research based.
- The therapist was able to evaluate the client’s progress in therapy.
- The therapist demonstrated the ability to implement creative interventions that were appropriate for the client.
10. Self-of-Therapist

An assessment of possible transference and counter transference considerations

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<tr>
<th>Rating</th>
<th>Description</th>
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<tr>
<td>DEFICIENT</td>
<td>The therapist did not provide transference and countertransference considerations.</td>
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<tr>
<td>BELOW EXPECTATIONS</td>
<td>The therapist demonstrated a poor understanding of transference and countertransference considerations.</td>
</tr>
<tr>
<td>MEETS EXPECTATIONS</td>
<td>The therapist demonstrated the ability to clearly articulate transference and countertransference considerations.</td>
</tr>
<tr>
<td>EXCEEDS EXPECTATIONS</td>
<td>The therapist demonstrated the ability to clearly and skillfully articulate transference and countertransference considerations.</td>
</tr>
<tr>
<td>EXCEPTIONAL SKILLS</td>
<td>The therapist demonstrated the ability to clearly and sophisticatedly articulate transference and countertransference considerations.</td>
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</table>

11. Ethical and Legal Issues

A discussion of possible ethical/legal considerations and how they would be addressed. Include a discussion of the identification and management of any legal/ethical obligations and mandates that apply specifically to the case.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
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</thead>
</table>
| DEFICIENT              | The therapist had significant problems in applying and managing legal and ethical standards and mandates in clinical practice specific to the case.  
  - The therapist did not take appropriate action concerning potential self-harm, suicide, abuse, or violence.  
  - The therapist did not monitor implications of legal actions.  
  - The therapist failed to abide by the policies and procedures of their clinical training site.  
  - The therapist failed to demonstrate an understanding of the process of ethical decision making. |
| BELOW EXPECTATIONS      | The therapist had minor problems in applying and managing legal and ethical standards and mandates in clinical practice specific to the case.  
  - The therapist did not assess and manage more than one legal/ethical issue relevant to the case.  
  - The therapist did not maintain client records with timely and accurate notes.  
  - The therapist did not recognize when to use clinical supervision and consultation in relation to legal issues.  
  - The therapist failed to inform the client of the parameters of therapy (including reporting and confidentiality). |
| MEETS EXPECTATIONS      | The therapist sufficiently applied and managed legal and ethical standards and mandates in clinical practice specific to the case.  
  - The therapist took appropriate action when dealing with legal issues.  
  - The therapist reported essential information to appropriate authorities as required by law. |
• The therapist informed clients and legal guardians of the limitations of confidentiality and parameters of mandatory reporting.
• The therapist practiced within the scope of practice and competence.
• The therapist demonstrated an awareness of professional boundaries.

EXCEEDS EXPECTATIONS
The therapist skillfully applied and managed legal and ethical standards and mandates in clinical practice specific to the case.
• The therapist utilized supervision and consultation in managing legal and ethical concerns.
• The therapist practiced within the scope of practice and the scope of competence.
• The therapist monitored attitudes, personal well-being, personal issues, and subjective countertransference to ensure they do not impact the therapeutic process.

EXCEPTIONAL SKILLS
The therapist sophisticatedly applied and managed legal and ethical standards and mandates in clinical practice specific to the case.
• The therapist demonstrated knowledge of complex and subtle legal obligations.
• The therapist monitored relevant legal issues throughout the case.
• The therapist obtained additional training and consultation in relation to specific legal issues (competency).
• The therapist pursued professional development through supervision, consultation and self-study.

12. Diversity Considerations

Discuss any diversity (including but not limited to race, age, gender, ethnicity, sexual orientation, gender identity, socioeconomic status, disability, health status, religious, spiritual and/or political beliefs, nation of origin or other relevant social categories, immigration or language) considerations and how they may impact treatment. Include discussion on marginalized and/or underserved communities when applicable.

The discussion should focus on:

• **Cultural identity** (ethnic/cultural reference). Cultural identity should be explored for all clients and not just minority clients. For immigrants and ethnic minorities, note the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use and preference (including multilingualism).

• **Cultural factors related to psychosocial environment and levels of functioning**: Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

• **Diversity elements of the relationship between the individual and the clinician**: Indicate differences in diversity related factors between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural
significance, in negotiating an appropriate relationship or level of intimacy, in
determining whether a behavior is normative or pathological).

- **Overall assessment of diversity related factors for diagnosis and care:**
The formulation concludes with a discussion of how diversity considerations
specifically influence comprehensive diagnosis and care.

<table>
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<tr>
<th>Score</th>
<th>Description</th>
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</table>
| DEFICIENT | The therapist had significant problems identifying cultural factors influencing the presenting problem and provided interventions inconsistent with the client’s context.  
- The therapist lacked awareness of diversity issues which resulted in a bias negatively impacting treatment. |
| BELOW EXPECTATIONS | The therapist had minor problems identifying cultural factors influencing the presenting problem and provided interventions inconsistent with the client’s context.  
- The therapist failed to monitor personal reactions to the client and treatment process.  
- The therapist failed to identify important contextual and relational issues. |
| MEETS EXPECTATIONS | The therapist sufficiently identified cultural factors influencing the presenting problem and provided interventions consistent with the client’s context.  
- The therapist recognized contextual and systemic dynamics (e.g. age, gender, socioeconomic status, culture, race, ethnicity, religion etc.).  
- The therapist diagnosed and assessed the client’s behavior(s) and relational health problems systemically and contextually.  
- The therapist integrated the client’s feedback, assessment, contextual information, and diagnosis with the treatment goals.  
- The therapist evaluated reactions to the treatment process and the impact on effective intervention and clinical outcomes. |
| EXCEEDS EXPECTATIONS | The therapist skillfully identified cultural factors influencing the presenting problem and provided interventions consistent with the client’s context.  
- The therapist integrated relational and contextual issues throughout the treatment process.  
- The therapist delivered interventions in a way that was sensitive to the special needs of the client(s). |
| EXCEPTIONAL SKILLS | The therapist sophisticatedly identified cultural factors influencing the presenting problem and provided interventions consistent with the client’s context.  
- The therapist explored with the client the impact of contextual and relational issues in relation to the presenting problem.  
- The therapist demonstrated respect for multiple perspectives. |
13. Case Management

**Case management** considerations (consents and initial structuring of treatment, who attends sessions, managing family secrets, missed appointments, crisis management, referrals, termination, etc.)

Deficient=1, Below Expectations=2, Meets Expectations=3, Exceeds Expectations=3, Exceptional Skills=3

| DEFICIENT                                                                 | The therapist provided an incomplete and/or unclear identification of crises issues, poor crisis management, and/or no planned continuation of management of crisis issue(s) in treatment. The therapist provided poor case management.  
|                                                                          | - The therapist did not assess or manage crisis issues.  
|                                                                          | - The therapist did not manage crisis issues according to relevant state, federal, and provincial laws and regulations.  
|                                                                          | - The therapist made inappropriate referrals. |
| BELOW EXPECTATIONS                                                      | The therapist did not clearly identify and/or missed significant crisis issues. The therapist managed crisis situations and the case superficially.  
|                                                                          | - The therapist did not assess or manage potential crisis issues.  
|                                                                          | - The therapist superficially managed crisis issues according to relevant state, federal, and provincial laws and regulations.  
|                                                                          | - The therapist did not make appropriate referrals. |
| MEETS EXPECTATIONS                                                      | The therapist sufficiently identified and responded to crisis issues and managed the case appropriately.  
|                                                                          | - The therapist assisted the client in obtaining needed care while navigating the complex systems of care.  
|                                                                          | - The therapist managed risks, crises, and emergencies.  
|                                                                          | - The therapist worked collaboratively with other stakeholders, including family members and other professionals.  
|                                                                          | - The therapist provided the client with appropriate referrals.  
|                                                                          | - The therapist developed an appropriate aftercare plan that was relevant to the case. |
| EXCEEDS EXPECTATIONS                                                    | The therapist skillfully managed the case and identified and responded to crisis issues appropriately.  
|                                                                          | - The therapist skillfully managed crisis issues, managed risks, and emergencies.  
|                                                                          | - The therapist skillfully worked with other stakeholders, including family members and other professionals.  
|                                                                          | - The therapist integrated use of referrals into treatment.  
|                                                                          | - The therapist skillfully developed an appropriate aftercare plan that was relevant to the case. |
| EXCEPTIONAL SKILLS                                                      | The therapist sophisticatedly managed the case and identified and responded to the crisis issues appropriately.  
|                                                                          | - The therapist integrated crisis management interventions into long-term treatment goals.  
|                                                                          | - The therapist sophisticatedly managed risks, crisis issues, and emergencies.  
|                                                                          | - The therapist sophisticatedly collaborated with other stakeholders, including family members and other professionals. |
- The therapist integrated use of referrals into treatment.
- The therapist sophisticatedly developed an appropriate aftercare plan that was relevant to the case.

### 14. Client-Centered Advocacy

**Client-centered advocacy (CCA)** (any adjunctive services that would be important to meeting treatment goals including referrals, telephone conversations, and other CCA-related activities)

Deficient=1, Below Expectations=2, Meets Expectations=3, Exceeds Expectations=3, Exceptional Skills=3

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFICIENT</td>
<td>The therapist did not provide client-centered advocacy when required.</td>
</tr>
<tr>
<td></td>
<td>- The therapist made inappropriate referrals or did not make appropriate referrals when required.</td>
</tr>
<tr>
<td></td>
<td>- The therapist did not work with other stakeholders, including family members and other professionals when it would have been helpful to do so.</td>
</tr>
<tr>
<td>BELOW EXPECTATIONS</td>
<td>The therapist provided superficial client-centered advocacy.</td>
</tr>
<tr>
<td></td>
<td>- The therapist did not make appropriate referrals when required.</td>
</tr>
<tr>
<td></td>
<td>- The therapist did not work collaboratively with other stakeholders, including family members and other professionals.</td>
</tr>
<tr>
<td>MEETS EXPECTATIONS</td>
<td>The therapist provided client-centered advocacy sufficiently.</td>
</tr>
<tr>
<td></td>
<td>- The therapist assisted the client in obtaining needed care while navigating the complex systems of care.</td>
</tr>
<tr>
<td></td>
<td>- The therapist worked collaboratively with other stakeholders, including family members and other professionals.</td>
</tr>
<tr>
<td></td>
<td>- The therapist provided the client with appropriate referrals.</td>
</tr>
<tr>
<td>EXCEEDS EXPECTATIONS</td>
<td>The therapist skillfully provided client-centered advocacy.</td>
</tr>
<tr>
<td></td>
<td>- The therapist skillfully assisted the client in obtaining needed care while navigating the complex systems of care.</td>
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<td></td>
<td>- The therapist integrated use of referrals into treatment.</td>
</tr>
<tr>
<td>EXCEPTIONAL SKILLS</td>
<td>The therapist sophisticatedly provided client-centered advocacy.</td>
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<tr>
<td></td>
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<td></td>
<td>- The therapist sophisticatedly collaborated with other stakeholders, including family members and other professionals.</td>
</tr>
<tr>
<td></td>
<td>- The therapist integrated use of referrals into treatment.</td>
</tr>
</tbody>
</table>
15. Evaluation of Therapy Process

**Evaluation of the therapeutic process to date**, including an assessment of the therapeutic relationship

Deficient=1, Below Expectations=2, Meets Expectations=3, Exceeds Expectations=3, Exceptional Skills=3

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>DEFICIENT</strong></td>
<td>The therapist did not provide a description of the therapeutic process to date.</td>
</tr>
<tr>
<td><strong>BELOW EXPECTATIONS</strong></td>
<td>The therapist demonstrated a superficial description of the therapeutic process to date.</td>
</tr>
<tr>
<td><strong>MEETS EXPECTATIONS</strong></td>
<td>The therapist demonstrated the ability to clearly articulate the therapeutic process to date.</td>
</tr>
<tr>
<td><strong>EXCEEDS EXPECTATIONS</strong></td>
<td>The therapist demonstrated the ability to clearly and skillfully articulate the therapeutic process to date.</td>
</tr>
<tr>
<td><strong>EXCEPTIONAL SKILLS</strong></td>
<td>The therapist demonstrated the ability to clearly and sophisticatedly articulate the therapeutic process to date.</td>
</tr>
</tbody>
</table>
Comprehensive Written Case Report Evaluation Form

Student’s Name__________________________  Date_____________________

Please evaluate the student according to the following grading criteria:

Deficient - 1, Below Expectations - 2, Meets Expectations - 3, Exceeds Expectations - 3,
Exceptional Skills – 3

1. Identifying Info / Genogram

Please circle the appropriate number based on the student's performance:

Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:

2. Systemic Assessment

Please circle the appropriate number based on the student's performance:

Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:

3. Diagnosis

Please circle the appropriate number based on the student's performance:

Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:

4. Case Conceptualization

Please circle the appropriate number based on the student's performance:

Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:
5. **Theoretical Model**

Please circle the appropriate number based on the student’s performance:

Deficient – 1, Below Expectations – 2, Meets Expectations – 3, Exceeds Expectations – 3, Exceptional Skills – 3

Narrative Comments:

6. **Treatment Goals**

Please circle the appropriate number based on the student’s performance:

Deficient – 1, Below Expectations – 2, Meets Expectations – 3, Exceeds Expectations – 3, Exceptional Skills – 3

Narrative Comments:

7. **Theory of Change**

Please circle the appropriate number based on the student’s performance:

Deficient – 1, Below Expectations – 2, Meets Expectations – 3, Exceeds Expectations – 3, Exceptional Skills – 3

Narrative Comments:

8. **Role of Therapist**

Please circle the appropriate number based on the student’s performance:

Deficient – 1, Below Expectations – 2, Meets Expectations – 3, Exceeds Expectations – 3, Exceptional Skills – 3

Narrative Comments:

9. **Research-Based Interventions**

Please circle the appropriate number based on the student’s performance:

Deficient – 1, Below Expectations – 2, Meets Expectations – 3, Exceeds Expectations – 3, Exceptional Skills – 3

Narrative Comments:
10. Self-of-Therapist

Please circle the appropriate number based on the student’s performance:
Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:

11. Ethical and Legal Issues

Please circle the appropriate number based on the student's performance:
Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:

12. Diversity Considerations

Please circle the appropriate number based on the student's performance:
Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:

13. Case Management

Please circle the appropriate number based on the student’s performance:
Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:

14. Client-Centered Advocacy

Please circle the appropriate number based on the student’s performance:
Deficient – 1, Below Expectations – 2, Meets Expectations– 3, Exceeds Expectations– 3, Exceptional Skills – 3

Narrative Comments:
15. Evaluation of Therapy Process

Please circle the appropriate number based on the student's performance:

Deficient – 1, Below Expectations – 2, Meets Expectations – 3, Exceeds Expectations – 3, Exceptional Skills – 3

Narrative Comments:

Decision:

______ Passed
______ Passed with recommendations
______ Failed with stipulations

______________________________________
Supervisor's Signature

______________________________________
Supervisor's Printed Name
ORAL CASE PRESENTATION EVALUATION FORM

Therapist _______________________________ Date __________________________

Supervisor ______________________________

Decision:
____ Passed
____ Passed with Recommendations
____ Failed with Stipulations

Case Details

<table>
<thead>
<tr>
<th>Case Details</th>
<th>Inadequate Information</th>
<th>Deficient</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
</tr>
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<tbody>
<tr>
<td>1. Identifying Info / Genogram</td>
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<tr>
<td>2. Systemic Assessment</td>
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<td>3. Diagnosis</td>
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<td>4. Case Conceptualization</td>
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<td>6. Treatment Goals</td>
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<td>7. Theory of Change</td>
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<td>8. Role of Therapist</td>
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<td>9. Research-Based Interventions</td>
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<td>10. Self-of-Therapist</td>
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<td>12. Diversity Considerations</td>
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<td>13. Case Management</td>
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<td>14. Client-Centered Advocacy</td>
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<tr>
<td>15. Evaluation of Therapy Process</td>
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</table>

0 = Inadequate Information - unable to assess due to lack of information or opportunities to develop skill
1 = Deficient - incomplete understanding; poor application of skill; harmful or unprofessional behavior
2 = Below Expectations - some understanding of concept; recognize in hindsight how might have been applied
3 = Meets Expectations - demonstrates expected level of competence in comprehension and application of clinical skills
3 = Exceeds Expectations - demonstrates above average level of competence in comprehension and application of clinical skills
3 = Exceptional Skills - demonstrates superior level of competence in comprehension and application of clinical skills

Narrative Feedback:
ORAL CASE PRESENTATION QUESTIONS

Instructions: Please utilize the questions below for the questions and discussion portion of the Oral Case Presentation. Please evaluate the student’s response according to the following grading criteria:

Deficient=1, Below Expectations=2, Meets Expectations=3, Exceeds Expectations=3, Exceptional Skills=3

Student’s Name: ____________________________________________________________

1. Discuss how you assessed and managed the crisis of __________________________ for this client?
   Rating: ______

2. Discuss how you assessed and managed the legal/ethical issue of __________________ with this case?
   Rating: ______

3. How well does your intervention, ______________________________, apply to the client at this particular stage in treatment? Rating: ______

4. What other possible diagnoses for this client did you consider and how did you rule them out?
   Rating: ______

5. How have diversity related factors impacted treatment in this case? Rating: ______

6. How have you managed transference and counter transference with this case?
   Rating: ______

7. What is it like for you as a therapist to work with this client? Rating: ______

8. What are some of the barriers to treatment you see in working with this client? Rating: ______

9. What issues in working with this client have challenged you to discuss them with your MFT supervisor? Rating: ______

10. Talk about one referral you made or would make and discuss the expected outcome of the referral.
    Rating: ______
CAPSTONE PROJECT: FINAL EVALUATION FORM

Student's Name___________________________  Date _________________________

A. Theory of Change Paper Decision
   ___ Passed
   ___ Passed with Recommendations
   ___ Failed with Stipulations

B. Comprehensive Written Case Report Decision
   ___ Passed
   ___ Passed with Recommendations
   ___ Failed with Stipulations

C. Oral Case Presentation Decision
   ___ Passed
   ___ Passed with Recommendations
   ___ Failed with Stipulations

Final Capstone Project Decision
   ___ Passed
   ___ Passed with Recommendations
   ___ Failed with Stipulations

Recommendations (if applicable):

Stipulations (if applicable):

___________________________________  ______________________________
Supervisor's Signature    Supervisor's Printed Name
DEFINITIONS: The following situations are reportable conditions:

1. Physical abuse
2. Sexual abuse
3. Child exploitation and pornography and child prostitution
4. Severe or general neglect
5. Extreme corporal punishment resulting in injury
6. Willful cruelty or unjustifiable punishment
7. Abuse or neglect in out-of-home care

WHO MUST REPORT: The following individuals are legally mandated reporters (refer to “Reporting Law” section for a comprehensive listing):

- Child visitation monitors
- Health practitioners (nurses, physicians, etc.)
- Commercial or photographic print processors in specified instances
- Specified public positions (teachers, social workers, probation officers, etc.)
- Public protection positions (police, sheriff, CPS, etc.)
- Clergy members
- Fire fighters (except volunteer firefighters), animal control officers, Humane Society officers

WHEN TO REPORT: A telephone report must be made immediately when the reporter observes a child in his/her professional capacity or within the scope of his/her employment and has knowledge of, or has reasonable suspicion that the child has been abused. A written report on a standard form must be sent within 36 hours after the telephone report has been made.

TO WHOM DO YOU REPORT: You have a choice of reporting to the Police or Sheriff’s Department or the Probation Department or Child Welfare Agency. Each County has preferred reporting procedures. Commercial film or photographic processors report only to law enforcement.

INDIVIDUAL RESPONSIBILITY: Any individual whose occupation is named in the reporting law must report abuse. If the individual confers with a superior and a decision is made that the superior file the report, one report is sufficient. However, if the superior disagrees, the individual with the original suspicion must report.

ANONYMOUS REPORTING: Mandated reporters are required to give their names. Non-mandated reporters may report anonymously. Child protective agencies are required to keep mandated reporter’s name confidential, unless a court orders the information disclosed.

IMMUNITY: Any legally mandated reporter has immunity when making a report. In the event a civil suit is filed against the reporter, reimbursement for fees incurred in the suit will occur up to $50,000 (P.C. Section 11172). No individual can be dismissed, disciplined, or harassed for making a report of suspected child abuse.

LIABILITY: Legally mandated reporters can be criminally liable for failing to report suspected abuse. The penalty for this misdemeanor is up to six months in county jail, a fine of not more than $1,000, or both. Mandated reporters can also be civilly liable for failure to report.

NOTIFICATION REGARDING ABUSE: You are not legally required to notify the parents that you are making a report; however, it is often beneficial to let the parents know you are reporting for benefit of a future relationship.

I understand that I am a legally mandated reporter. I have clarified any information listed above which I did not understand, and am now aware of my reporting responsibilities, and am willing to comply. I have also requested an explanation of reporting policies within this age and understand them.

Employee’s Signature: ___________________________ Date: ________________

Director: ________________________
FRANCES SMITH CENTER FOR INDIVIDUAL AND FAMILY THERAPY

CHILD/ADOLESCENT INTAKE FORM

Child’s Name: ___________________________ Date of Birth: ____________

Child’s School: ________________________________________________________

Teacher’s Name: __________________________________ Grade: ____________

FAMILY STRUCTURE:

Mother/Stepmother: _______________________ DOB: __________ Occupation:_____

Father/Stepfather: ________________________ DOB: __________ Occupation:_____

Name(s) of natural parents (if different from above):

Mother: ___________________________ DOB: __________ Occupation:_____

Father: ___________________________ DOB: __________ Occupation:_____

Siblings (Name and Age): _________________________________________________

Others living in the home: _______________________________________________

Current Address: _______________________________________________________

Street Address

__________________________________________________

City Zip Code

Telephone No.: ( ) ______________________ ( ) ______________________

What is currently concerning you about your child/teenager? ____________________________

________________________________________

________________________________________

________________________________________

________________________________________

When did the problem start? ______________________________________________________

________________________________________

Can you recall any life circumstances or family changes at the time the problem(s) started? ______________________________

________________________________________

________________________________________

________________________________________

________________________________________
What has been done to alleviate the problem (i.e., other referrals, clinics, professional help, etc.)

Has your child received previous counseling or been tested?  ___Yes  ___No
Name(s)  Address  Dates of Service

Has your child/teen been hospitalized for psychological/psychiatric reasons?  ____Yes  ___No
Hospital(s)  Address  Dates of Hospitalization

FAMILY HISTORY: Please indicate which of the following is true for your child/teen or any other family
members:

<table>
<thead>
<tr>
<th>Depression</th>
<th>Child</th>
<th>Mother</th>
<th>Father</th>
<th>Sibling</th>
<th>Grandparent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Attempts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental/Emotional Problems</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

MEDICAL HISTORY: If your child's medical history includes any of the following, please note the age when the incident
or illness occurred and any other pertinent information:

<table>
<thead>
<tr>
<th>___Yes  ___No</th>
<th>Childhood diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>___Yes  ___No</td>
<td>Operations</td>
</tr>
<tr>
<td>___Yes  ___No</td>
<td>Hospitalizations for illness(es) other than operations</td>
</tr>
<tr>
<td>___Yes  ___No</td>
<td>Head Injuries</td>
</tr>
<tr>
<td>___Yes  ___No</td>
<td>Convulsions</td>
</tr>
<tr>
<td>___Yes  ___No</td>
<td>Meningitis or encephalitis</td>
</tr>
<tr>
<td>___Yes  ___No</td>
<td>Immunization reactions</td>
</tr>
<tr>
<td>___Yes  ___No</td>
<td>Persistent high fevers</td>
</tr>
<tr>
<td>___Yes  ___No</td>
<td>Eye problems</td>
</tr>
<tr>
<td>___Yes  ___No</td>
<td>Ear Problems</td>
</tr>
</tbody>
</table>

Your overall rating of your child's health:  ____Healthy  ____Normal  ____Sickly

Name/Address of Physician:  

Date of last physical exam:  

Present illness(es) your child is being treated for:  

Medications child is taking on an ongoing basis:  

Page 120 of 210
**PREGNANCY:** Were there any complications during pregnancy?  
___Yes  ___No  
___Excessive Vomiting  ___Operation(s)  
___Toxemia  ___Illness(es)  
___Hospitalization or Bed rest required  ___Infection(s)  
___Excessive staining/blood loss  ___Threatened Miscarriage  
___Low APGAR Scores  ___Oxygen deprived (i.e., Blue)  
___Yes  ___No  Smoking during pregnancy  
___Yes  ___No  Alcohol consumption during pregnancy  
___Yes  ___No  Medications taken during pregnancy  (List)  
___Yes  ___No  X-Rays taken during pregnancy  (List)  
___Yes  ___No  Was the birth premature? If yes, how early?  

**DELIVERY:** Were there any complications during delivery?  
___Yes  ___No  
___Cord around neck  ___Infant injured delivery  
___Hemorrhage  ___Breach  
___Cord presented first  ___Other  

Birth Weight (if known):  pounds   ounces   APGAR Score (if known):  

Total number of days in the hospital after delivery:  Baby:  Mother:  

___Yes  ___No  Did your child suffer from any complications after birth? If yes, please list:

**INFANCY-TODDLER PERIOD:** Were any of the following present -- to a significant degree -- during the first few years of life?  
___Did not enjoy cuddling  ___Excessive restlessness  
___Was not calmed by being held and/or stroked  ___Diminished sleep due to restlessness/easy arousal  
___Colic  ___Constantly into everything  
___Excessive number of accidents compared to other  ___Other  

**DEVELOPMENTAL MILESTONES:**  

<table>
<thead>
<tr>
<th>DEVELOPMENTAL MILESTONES</th>
<th>I CANNOT RECALL EXACTLY BUT TO BEST OF RECOLLECTION IT OCCURRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smiled</td>
<td>AGE</td>
</tr>
<tr>
<td>Sat without support</td>
<td></td>
</tr>
<tr>
<td>Walked without assistance</td>
<td></td>
</tr>
<tr>
<td>Walked without assistance</td>
<td></td>
</tr>
<tr>
<td>Spoke first words besides</td>
<td></td>
</tr>
<tr>
<td>Bowel trained</td>
<td></td>
</tr>
<tr>
<td>Rode bicycle (no train. wheels)</td>
<td></td>
</tr>
<tr>
<td>Said Alphabet in order</td>
<td></td>
</tr>
<tr>
<td>Named Colors</td>
<td></td>
</tr>
<tr>
<td>Began to read</td>
<td></td>
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</tbody>
</table>

**COMPLETED BY:**  
Signature of Parent/Guardian  Date  

**REVIEWED BY:**  
Signature of MFT Trainee  Date
Child’s Name: ________________________________
Date of Birth: ________________________________

CUSTODY OF A MINOR

When treating a minor child/adolescent, it is our policy to obtain the consent of both parents in cases where the parents are separated, divorced, or never married, whenever possible and appropriate. While custody documents may allow one parent to obtain therapy without the consent of the other parent, generally it is in your child’s best interests to have the consent and agreement of both parents prior to the commencement of therapy. This can reduce the possibility of one parent interfering or actually rendering your child’s therapy ineffective.

Please read the following information options, check the appropriate box, and fill in any information that is requested. Then date and sign below. If there are any corrections to be made, please let me know immediately.

☐ Parents are divorced and share legal custody. _________________ (mother/father) has primary physical custody. Consent of both parents will be obtained.

☐ Parents are divorced and ________________________ has full legal and physical custody. Copy of custody order confirming this information will be obtained and attached to this form.

☐ Parents are divorced and I do not know how to contact child’s other parent to obtain consent.

☐ Parents are divorced and my child’s other parent has not been involved in child’s life since ________________________________.

☐ Parents were never married and I do not know how to contact child’s other parent to obtain consent.

☐ Parents were never married and my child’s other parent has not been involved in child’s life since ________________________________.

☐ Other: ____________________________________________

I certify under penalty of perjury that the above information is true and correct.

Dated: ____________________ ____________________
Signature of Parent/Guardian

Print Name: ________________________________
<table>
<thead>
<tr>
<th>DATE</th>
<th>NOTES</th>
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</table>
CCA NOTE

CLIENT: ___________________________ DATE: _______________

CCA ACTIVITY: CCA TIME: ___________

☐ Identify/research support group: __________________________________________

☐ Identify/research psychiatric evaluation: ___________________________________

☐ Identify/research low cost medical services: _______________________________

☐ Identify/research low cost legal services: _________________________________

☐ Identify/research psychoeducational class: ________________________________

☐ Identify/research substance abuse treatment: ______________________________

☐ Identify/research adjunctive services: Specify: ____________________________

☐ Telephone call to advocate for client with another professional (NOTE: must have a signed release)
   Specify: __________________________________________________________________

☐ Telephone consultation with another professional on a particular clinical issue or specialty (e.g.,
   therapist who specializes in transgender issues), without need for release as client's identity is not
   disclosed. Specify: ________________________________________________________

☐ Other: ___________________________________________________________________

Brief description of CCA activity listed above, including the resources/referrals that were found, purpose of
CCA, and how information was given to client: (NOTE: attach copies of any lists or documents that are given to
client).

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Signed: ___________________________ DATE: ________________
DAILY CHECKLIST TO CLOSE UP THE CENTER

<table>
<thead>
<tr>
<th>MON</th>
<th>TUES</th>
<th>WED</th>
<th>THUR</th>
<th>FRI</th>
<th>SAT</th>
</tr>
</thead>
</table>

Initial item(s) you have completed -- ALL items must be completed by the last person in the Center.

**WEEK OF:**

**AUDIO VISUAL ROOM -- ROOM 112A**
- All monitors off
- All speakers off
- Ensure no devices are recording

**LIGHTS OFF AND "IN SESSION" SIGNS CLEAR**
- Room 113        SOUND MACHINES TURNED OFF
- Room 114        SOUND MACHINES TURNED OFF
- Room 115
- Room 116
- Room 112B
- Room 112C
- Room 112D
- Room 113E
- Lobby -- Room 122

**ALL HALL SOUND MACHINES TURNED OFF**
- Hall light

**ROOM 123 -- MAIN CENTER OFFICE**
- Lobby sliding window locked and secured
- Flash drive tray placed in back of File Cab. #2
- File cabinet 1 locked
- File cabinet 2 locked
- File cabinet 3 locked
- ALL keys in key box and box LOCKED

**FRONT DOOR TO LOBBY IS COMPLETELY CLOSED**

(Revised 6/28/18)
DRESS CODE

This dress code is intended to contribute to the overall professional development of graduate students in the profession of psychotherapy as Marriage and Family Therapist trainees. The purpose of this code is to make the student aware that there is a standard of professional dress that should be adhered to in order for the student to have a more effective transition into the professional workplace. You have entered and are representing the MFT profession, the department of Psychology, your faculty and Chapman University. There will be times when opinions of the profession itself will be formed by the impression you make. How you look, what you say, how you say it, and even the way in which you direct your clients from the waiting area to the counseling room will reveal your regard for them and for yourself in relation to them. Respect for others is more than politeness: it is an attitude, a consistent regard for persons and their dignity. There is a role change that must be made when you transition from an academic setting to a clinical setting, a student role to a professional student role, and part of this change includes our attire.

What we wear is nonverbal communication. It's sending a message. Keep in mind that your dress may be clients' initial (possibly only) impression of you, so make it a good one to avoid clouding their judgment of your competence and knowledge by your image. In many cases you, the student, will have a greater obligation to place more emphasis on looking “professional” because you may be seen as young and not-so-knowledgeable. Don't give someone the opportunity to judge your skills on their impression from your dress.

All trainees and interns in the Frances Smith Center for Individual and Family Therapy are expected to contribute to a positive public image. You are aware of your role as a therapist, and the inherent power of the therapist in the clinical setting. As such you demonstrate good self-awareness with respect to the issues of transference and the establishment of safety in the therapy setting in furtherance of a good working alliance with the client.

The following standards are presented to assist you with determinations of appropriate dress for working in our department (observing or providing clinical services, in the waiting room, and in the clinic/business office). They are not meant to be all-inclusive; rather, use them in conjunction with your good judgment. For example, looser clothing increases your maneuverability in a variety of situations; this is a setting in which you may find yourself playing on the floor, sitting at a small child’s table, or pushing a wheelchair – be sure you can maneuver in those situations without baring skin or underwear. We work with a variety of clients, variety of ages, variety of parents – it is inappropriate to wear something that might be perceived as suggestive or revealing.

Business casual is the best description of appropriate dress for trainees and interns. Inappropriate dress includes, but is not limited to, the following:

- Worn-out garments or ones with holes
- Hats (religious head covering is an exception)
- Shorts of any kind
- NO jeans of any kind or color
- Any combination of clothing that exposes one’s midriff or lower back. (Stand in front of a mirror and raise your arms – if your midriff shows, do not wear it. Then bend over, if your lower back is exposed, do not wear it).
- Tattoos – Any clothing that reveals the location of a tattoo in an area that is typically hidden by clothing
• No baring shoulders (no off-the-shoulder tops, tank tops, halter tops, or anything sleeveless)
• Low-cut or sheer clothing
• Dirty, wrinkled, or disheveled clothing
• Beach or vacation clothing that is too casual
• Plastic or rubber flip-flops
• Any clothing or footwear deemed inappropriate by the supervisor, Clinic Director, or Program Director.

Observe others, ask questions, “figure it out”, and use your good judgment. Supervisors will also help you (so, if one talks with you about professional dress or asks you to change, take it for the learning opportunity that it’s meant to be). Ask yourself: “If a client/parent/supervisor/etc. were to have only my appearance to go by, what impression would they have?”

If you wear clothing that is deemed unprofessional according to the standards listed above, you will be asked to either go home and change.

I have read and understand the above information

DATE: ________________________________  Signature of Trainee

_____________________________________

Printed Name of Trainee
FEE AGREEMENT

CLIENT NAME(S):  

The average cost of a counseling session is approximately $100 per session. The cost of your counseling session at the Frances Smith Center for Individual and Family Therapy, however, is determined by our sliding scale which is based on monthly income.

Our sliding scale is based on gross income which refers to all sources of income including employment, child support, alimony, general relief, Aid to Families with Dependent Children (AFDC), Social Security, SSI, Disability, Unemployment, etc.

<table>
<thead>
<tr>
<th>Source of Income:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>SSI/Social Security</td>
<td></td>
</tr>
<tr>
<td>Child Support</td>
<td></td>
</tr>
<tr>
<td>AFDC/Welfare</td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td></td>
</tr>
<tr>
<td>Alimony</td>
<td></td>
</tr>
<tr>
<td>General Relief</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

Gross Monthly Income: $___________

Your Session Fee is: $___________

CLIENT FINANCIAL AGREEMENT

1. Based on my income, I agree to pay $_______ per counseling session to the Frances Smith Center.

2. I understand that the sessions are based on a 50-minute hour, and that payment is made at the time of the session. **I UNDERSTAND THAT IT IS MY RESPONSIBILITY FOR PAYMENT IN FULL FOR ALL SESSIONS.**

3. I understand that it is my obligation to call at least 24 hours in advance if I am going to miss a session. Cancellation with less than 24 hours notice will be charged the full session fee of $_________ ("LATE CANCELLATION").

4. I understand that I will be charged the full session fee of $_________ for missed sessions where no notice was given ("NO SHOW").

5. I understand that two (2) NO SHOWS/LATE CANCELLATIONS or three (3) CANCELLATIONS may result in termination of counseling, and I will be given a list of other low cost clinics as referrals.

Dated: __________________________  Signature of Client (or Parent/Guardian)

Dated: __________________________  Signature of MFT Trainee

Dated: __________________________  Signature of Clinic Director  (Rev. 4/30/2014)
FEE REDUCTION

CLIENT NAME(S): _____________________________________________________________

The average cost of a counseling session is approximately $100 per session. The cost of your counseling session at the Frances Smith Center for Individual and Family Therapy, however, is determined by our sliding scale which is based on monthly income.

Our sliding scale is based on gross income which refers to all sources of income including employment, child support, alimony, general relief, Aid to Families with Dependent Children (AFDC), Social Security, SSI, Disability, Unemployment, etc.

According to the information you have provided, your fee has been determined as follows. Source of Income:

- Employment
- SSI/Social Security
- Child Support
- AFDC/Welfare
- Unemployment
- Disability
- Alimony
- General Relief
- Other:

Gross Monthly Income: $___________  Your Session Fee is:  $___________

I REQUEST A 25% FEE REDUCTION.  REDUCED SESSION FEE IS: $___________

This fee reduction will remain in effect until:

- I become employed
- My benefits become effective (i.e., unemployment, disability, etc.)
- I am employed full-time
- Other:


CLIENT FINANCIAL AGREEMENT

1. Based on my income, I agree to pay $_______ per counseling session to the Frances Smith Center.

2. I understand that the sessions are based on a 50-minute hour, and that payment is made at the time of the session. I UNDERSTAND THAT IT IS MY RESPONSIBILITY FOR PAYMENT IN FULL FOR ALL SESSIONS.

3. I understand that it is my obligation to call at least 24 hours in advance if I am going to miss a session. Cancellation with less than 24 hours notice will be charged the full session fee of $_________ (“LATE CANCELLATION”).

4. I understand that I will be charged the full session fee of $_______________ for missed sessions where no notice was given (“NO SHOW”).

5. I understand that two (2) NO SHOWS/LATE CANCELLATIONS or three (3) CANCELLATIONS may result in termination of counseling, and I will be given a list of other low cost clinics as referrals.

6. I understand that it is my responsibility to notify my counselor when my financial situation changes, at which time my fee will be reassessed.

Dated: ___________________________  _______________  Signature of Client (or Parent/Guardian)

Dated: ___________________________  ___________________________  Signature of MFT Trainee

Dated: ___________________________  ___________________________  Signature of Clinic Director  (Rev. 1/23/2015)
**FILE CHECKLIST**

**CLIENT NAME:** ________________________________  **MFT TRAINEE:** ________________________________

<table>
<thead>
<tr>
<th>DATE to do</th>
<th>FORM/DESCRIPTION</th>
<th>DUE BY</th>
<th>COMMENTS: (Things you need to do)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initial Intake</td>
<td>Session 1</td>
<td>□ OK  Missing:________________</td>
</tr>
<tr>
<td></td>
<td>General Intake (Adult)</td>
<td>Session 1</td>
<td>□ OK  Missing:________________</td>
</tr>
<tr>
<td></td>
<td>Child/Adolescent Intake</td>
<td>Session 1</td>
<td>□ OK  Missing:________________</td>
</tr>
<tr>
<td></td>
<td>Informed Consent</td>
<td>Session 1</td>
<td>□ OK  Missing:________________</td>
</tr>
<tr>
<td></td>
<td>Research Agreement</td>
<td>Session 1</td>
<td>□ OK  Missing:________________</td>
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<tr>
<td></td>
<td>Financial Agreement</td>
<td></td>
<td></td>
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<td></td>
<td>Fee Reduction</td>
<td>Session 1</td>
<td>□ OK  Missing:________________</td>
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<td></td>
<td>Mental Status</td>
<td>Session 1</td>
<td>□ OK  Missing:________________</td>
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<tr>
<td></td>
<td>Intake Assessment Form (Individual/Couple/Child)</td>
<td>Session 1-2</td>
<td>□ OK  Missing:________________</td>
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</table>

**Releases signed:**

<table>
<thead>
<tr>
<th>Previous Therapy:</th>
<th>No</th>
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<tbody>
<tr>
<td>Psychiatrist/M.D.:</td>
<td>No</td>
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</tr>
<tr>
<td>Psych Hospitalization(s):</td>
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<td>Yes</td>
</tr>
<tr>
<td>School Teacher/Counselor:</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Probation Officer/Court:</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
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</tbody>
</table>

**Session 3**

<table>
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<tr>
<th>Name</th>
<th>Release sent</th>
<th>Info Received</th>
</tr>
</thead>
</table>

**Session 3/4**

| Intake Summary (Reviewed and signed by supervisor) | □ OK  Missing:________________ |

**Psychological Testing:** Test(s): ________________________________ □ OK  Missing:________________

(All tests dated and scored)

**Fee Record:** All dates of service and payment are logged consistent with process notes □ OK  Missing:________________

Balance Due: $__________  □ OK  Missing:________________

Letter sent re: balance dated: ______________ □ OK  Missing:________________

Second letter re balance dated: ______________ □ OK  Missing:________________

**Supervisor Notes** Minimum of 1 signature per month □ OK  Missing:________________

**Process Notes** Each and every session/signed □ OK  Missing:________________

**Treatment Summary** Final reviewed and signed by Individual Supervisor □ OK  Missing:________________

Other items/comments:

1. _______________________________________

2. _______________________________________

(Rev. 1/2/17)
FRANCES SMITH CENTER FOR INDIVIDUAL & FAMILY THERAPY

INTAKE ASSESSMENT -- INDIVIDUAL

Client's Name: ____________________________________________________________
MFT Trainee: _____________________________________________________________
Date of Assessment: _____________________________

Today I am going to ask you questions about your life, including the reason you are seeking therapy, information about your background history, and what you’d like to accomplish here in therapy. There may be some questions that do not apply to you, and a simple “no” will do. The reason for this assessment is to make sure that this Center can provide you with the level of care that you need.

1. Tell me a little more about why you called the Frances Smith Center to begin therapy. What are the problems or issues that you would like help with?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. Can you tell me about any symptoms you are having? (For example, you aren’t sleeping well, you get angry for no reason, your heart beats rapidly and you feel as if you’re having a heart attack, etc.)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. When did the problem seem to begin, and what was going on in your life when the problem began? How long has it been going on (duration of the symptoms)? What made you decide to come to therapy now?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. What have you tried to do to fix this problem before deciding to seek therapy?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
5. Overall, how would you characterize your level of functioning at this time?

☐ Excellent  ☐ Good  ☐ Fair  ☐ Poor

6. At this time, what is your living situation? Do you live:

☐ Alone  With Others ____________  ☐ With Others ____________

Positive  Negative

7. Who is your primary source of support at this time?

☐ No support
☐ Family (List relationship(s)) ____________________________
☐ Friends (List names) ____________________________

8. What is your current employment situation at this time:

☐ Has never worked
☐ Has not worked for at least 1 year
☐ Recently lost job (list reason): ____________________________
☐ Works part-time (list occupation): ____________________________
☐ Works full-time (list occupation): ____________________________

9. Are you a student?

☐ No
☐ Part-time (list major, college) ____________________________
☐ Full-time (list major, college) ____________________________

10. Do you feel that some of your presenting problems are interfering with your ability to study, focus, concentrate, and/or make decisions?

☐ No
☐ Yes (List problems) ____________________________

HEALTH/MEDICAL ISSUES:

11. Are you having any health related problems at this time, including any chronic or serious illness or injury?

☐ No
☐ Yes – please describe: ____________________________

12. When is the last time that you saw a doctor? ____________________________

13. Do you have a primary care doctor (PCP)?

☐ Yes  ☐ No

IF YES, name of doctor and city: ____________________________

_____________________________
HISTORY OF PRIOR THERAPY:

14. Have you been in therapy in the past? □ YES □ NO

Name of Therapist | Focus of Treatment/Length of Treatment | Positive Experience
-------------------|----------------------------------------|-------------------
                    |                                        | □ Yes □ No
                    |                                        | □ Yes □ No
                    |                                        | □ Yes □ No

15. Did you follow the therapist’s suggestions related to your treatment goals? □ YES □ NO

HISTORY OF BEING HOSPITALIZED FOR PSYCHIATRIC REASONS:

16. Have you ever been hospitalized for psychiatric reasons before? □ YES □ NO

IF NO, SKIP TO NEXT PAGE

IF YES:

Name of Hospital | Length of Hospitalization | Was it involuntary
-----------------|---------------------------|-------------------
                  |                           | □ Yes □ No
                  |                           | □ Yes □ No

17. Tell me a little about what was going on at that time that resulted in you being hospitalized:


18. When you were hospitalized, were you put on any psychiatric medications? □ Yes □ No

19. If yes, do you remember what medications were prescribed?

20. Do you remember being told your diagnosis when you were hospitalized? □ Yes □ No

If yes, what was the diagnosis?
CURRENT PSYCHIATRIC MEDICATIONS:

21. Are you on any psychiatric medications right now?  □ Yes  □ No

IF NO, SKIP TO QUESTION #29

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

22. How long have you been taking these medications?  __________________________

23. Have you been told what your diagnosis is by the prescribing doctor?  □ Yes  □ No

24. If yes, what is your diagnosis?  ____________________________________________

25. What is the name of the doctor that has prescribed these medications?  __________________

26. Is your prescribing doctor a  □ Psychiatrist  OR  □ General/Family Practitioner

27. Do you take the medication(s) consistently in the manner the doctor has told you to do so?  □ Yes  □ No

IF YES: skip to Question #30

IF NO: Are you uncomfortable or reluctant to take the medications in the manner in which your doctor has recommended?  □ Yes  □ No

28. What are some of the reasons for this?

□ None  □ Family interference  □ Loss of insurance

□ Financial  □ Transportation  □ Diagnosis

□ Religious or other beliefs  □ Rapport with doctor

□ Other (please specify) __________________________________________________________

29. If not now, have you been prescribed psychiatric medications in the past?  □ Yes  □ No

If yes, list the medications: ______________________________________________________

Why did you stop taking the medication(s) in the past?

□ None  □ Family interference  □ Loss of insurance

□ Financial  □ Transportation  □ Diagnosis

□ Religious or other beliefs  □ Rapport with doctor

□ Other (please specify) __________________________________________________________
ASSESSING FOR SUICIDAL IDEATION:

30. Within the last 3 months, have you had any thoughts of suicide?
- [ ] None
- [ ] Thoughts only (no plan)
- [ ] Thoughts only (with plan)  Specify: ________________________________
- [ ] Plan with intent  Specify: ________________________________

31. In the past, have you ever made any suicide attempts?  [ ] Yes  [ ] No

IF NO, SKIP TO QUESTION #33

IF YES:

<table>
<thead>
<tr>
<th>Approx. Date</th>
<th>Method</th>
<th>Lethality of attempt</th>
<th>Hospitalized due to attempt</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Medium</td>
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<tr>
<td></td>
<td></td>
<td>High</td>
<td>Medium</td>
</tr>
</tbody>
</table>

32. Please tell me about what was going on at that time that led to you making a suicide attempt(s):

__________________________________________________________________________

__________________________________________________________________________

FAMILY HISTORY OF MENTAL ILLNESS:

33. In your family, both on your mother and father’s side, is there any history of:

Suicide attempts  [ ] YES  [ ] NO  Specify: ________________________________
Chronic mental illness  [ ] YES  [ ] NO  Specify: ________________________________
Chronic physical illness  [ ] YES  [ ] NO  Specify: ________________________________
History of impulsive behaviors  [ ] YES  [ ] NO  Specify: ________________________________

IF YES:

<table>
<thead>
<tr>
<th>Family member (including children)</th>
<th>Diagnosis (if known)</th>
<th>On Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes  No  Unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes  No  Unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes  No  Unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes  No  Unknown</td>
</tr>
</tbody>
</table>
34. I’d like to get a little more information about your history and events that may have shaped you in some way, what you might consider to be significant events in your life that have affected you

Family of origin (mother, father, siblings, etc.):  

Developmental history (events during childhood until becoming an adult – can include deaths, illnesses, moves, significant events, etc.):  

Relationship history (include marriages, divorces, children):  

Educational/Vocational History:  

Multi-cultural/Diversity History:  

Military History:  

IF CLIENT HAS REPORTED USE OF ALCOHOL ON TELEPHONE INTAKE, GET THE FOLLOWING INFORMATION:

35. How much alcohol do you drink on a regular basis? By that I mean, either daily, weekly, on weekends, rarely?

☐ None  
☐ None – I have been sober for ________________ weeks  months  years [circle]
☐ I drink rarely – maybe once or twice a year on special occasions

☐ I drink a total of _______________ drinks on a:

☐ Daily basis  ☐ Weekly basis  ☐ On weekends  ☐ Monthly  ☐ Binge drink

**What type of alcoholic drinks?**

☐ Beer  ☐ Wine  ☐ Mixed drinks  ☐ Shots  ☐ Hard liquor (vodka, gin, whiskey, etc.)

36. **Have you ever had a problem with alcohol in the past?**
   IF YES:

   ☐ Yes  ☐ No

37. **How old were you when you began drinking alcohol?**

38. **How long ago was it that your drinking was a problem?**

39. **Have you ever experienced any of the following after drinking too much?**

   ☐ Blackouts  ☐ Bad reactions  ☐ Withdrawal symptoms/Detox

40. **How would you describe your use of alcohol?**

   ☐ I am a social drinker  ☐ I am a heavy drinker  ☐ I am an alcoholic  ☐ Other: _____________

41. **Have you ever sought treatment for your alcohol problems in the past?**
   IF YES:

   Date   Agency/Provider   Outpatient OP/Inpatient IP   Was it helpful?

   ☐ Yes  ☐ No

42. **Do you have a family history of alcohol problems?**

   **Family Member**

   ☐ Father/Stepfather  ☐ Mother/Stepmother  ☐ Brother/Sister  ☐ Paternal Grandparent  ☐ Maternal Grandparent  ☐ Other _________________

   ☐ Yes  ☐ No
IF CLIENT HAS REPORTED USE OF SUBSTANCES ON TELEPHONE INTAKE, GET THE FOLLOWING INFORMATION:

43. Do you use any drugs (legal or illegal) on a regular basis? By that I mean, either daily, weekly, on weekends, rarely?
   □ None
   □ None – I have been clean for ________________ weeks/months, years
   □ I use them rarely – tell me the frequency _______________________________________
   □ I use drugs on a:
     □ Daily basis  □ Weekly basis  □ On weekends  □ Monthly  □ Other: ________________

44. What type of drugs do you use?  
   □ Amphetamines (speed, Meth, Ice)
   □ Opiates (Heroin, morphine, methadone, oxycodone, Norco, pain killers)
   □ Hallucinogens (LSD, mushrooms, Ecstasy)
   □ Inhalants
   □ Sedatives/Hypnotics (Xanax, Ativan, Valium, etc.)
   □ Marijuana (cannabis)
   [___] Age when you began using _________  [___] Last Used _________

If YES to marijuana, do you have a Medical marijuana card
   □ Yes  □ No
   If yes, prescribed by: ____________________________________________
   What is condition it is prescribed for: ________________________________

45. Have you ever had a problem with drug use in the past?  
   □ Yes  □ No

IF NO, SKIP TO NEXT PAGE

IF YES:

46. How long ago was it that your drug use was a problem? ____________________________________________

47. Have you ever experienced any of the following after your drug use?  
   □ Overdose  □ Bad reactions  □ Withdrawal symptoms/Detox  □ DUI

48. How would you describe your use of drugs?  
   □ I am a recreational drug user  □ I have a drug problem  □ I am an addict  □ Other: ________

49. Have you ever sought treatment for your drug problems in the past?  
   □ Yes  □ No

IF YES:

Date ___________  Agency/Provider ________  Inpatient IP ________  Was it helpful?
   □ Yes  □ No
   □ Yes  □ No
   □ Yes  □ No

50. Do you have a family history of drug problems?  
   □ Father/Stepfather  □ Paternal Grandparent
   □ Mother/Stepmother  □ Maternal Grandparent
   □ Brother/Sister  □ Other
   □ Yes  □ No
ASSESSING FOR AN EATING DISORDER:

51. Was there any time in your life that you had an eating disorder? □ Yes □ No

IF NO, SKIP TO NEXT PAGE

52. IF YES, how long ago did you have an eating disorder? __________________________

53. Have you ever been formally diagnosed with an eating disorder by a physician, therapist, or treatment facility? □ Yes □ No

54. Have you ever used any of the following methods due to concerns about your body size or weight?
   □ Restriction of food via dieting
   □ Exercise
   □ Binge Eating
   □ Purging (Vomiting)
   □ Use of Diet Pills/Diuretics (water pills)
   □ Use of Laxatives

55. If any of the above items are checked, what is the frequency of the behavior(s)?
   □ I have not engaged in the above behavior(s) for the last __________________ weeks/months.
   □ Monthly ______ times per month
   □ Weekly ______ times per week
   □ Daily ______ times per day

56. At the worst of times, what was the average frequency of these behaviors? __________________________

57. Have you ever sought treatment for an eating disorder? □ Yes □ No

IF YES:
Name of Treatment Center/City and State: __________________________
Type of Program: □ Outpatient □ Intensive Outpatient (IOP) □ Partial Hospitalization
□ Inpatient □ Other: __________________________

ASSESSING FOR AN ANGER PROBLEM:

58. Has anger ever been a problem for you? □ Yes □ No

IF NO, SKIP TO #68

59. In your own words, how has anger been a problem for you? __________________________

60. Tell me about your most recent episode of anger. What was happening at the time that led you to be angry? __________________________
61. Describe for me the most serious episode of anger that you have had in your life.

62. When you get mad or angry, do you ever become physically angry?  
☐ Yes  ☐ No  
If yes, describe it to me:

63. What have others that are close to you told you about your anger? If they were sitting here with us, how would they describe your anger?

64. How often do you get angry?  
☐ Daily  ☐ Weekly  ☐ Monthly  ☐ Other: ________

65. While growing up, how did members of your family show that they were mad or angry?

66. Have you ever been in trouble legally due to your anger?  
☐ Yes  ☐ No  
If yes, describe: ________________________________________________________________

67. Anything else that you think would be helpful for me to know about your anger that I haven’t already asked you about?
68. What would you like to accomplish here in therapy? It would be helpful to generate some goals related to the reason that you are seeking therapy, or what you would like my help with.

69. Generally when beginning therapy, it is recommended that we meet on a weekly basis. Is there any reason that you would not be able to come for weekly sessions?

70. Is there anything else that I may not have asked you specifically about, that you feel is important that I know about you or the reason you are seeking therapy at this time?
INTAKE THERAPIST’S OVERALL ASSESSMENT:
From the client’s information, it appears that their problem is: □ Acute □ Chronic

Can client articulate goals for therapy? □ Yes □ No
Is the client psychologically minded/able to take responsibility for own actions? □ Yes □ No
Is the client emotionally uncomfortable enough to want to seek help? □ Yes □ No
Does the client appear to be able to form a therapeutic alliance? □ Yes □ No
Does the client have realistic expectations for treatment? □ Yes □ No
Is the client able to be open and honest about him/herself? □ Yes □ No
Does the client appear to be appropriate for the Center? □ Yes □ No
Is the client capable of meeting weekly with therapist? □ Yes □ No

TEST RESULTS: List scores of any tests that were given as part of assessment:

☐ BAI = _______ BDI-II = _______ BHS = _______
☐ AUDIT or MAST = _______
☐ MOOD DISORDER QUESTIONNAIRE TOTAL = _______ CO-OCCURRING SYMPTOMS: YES / NO IMPAIRMENT: _______
☐ MAJOR DEPRESSION INVENTORY (ICD-10) = _______
☐ OQ-45 – Total: _______ SD = _______ IR = _______ SR = _______

Critical Items: #8 (SI) = _______ #11,26,32 (Subst Use) = _______ #44 (Anger) = _______

Dated: _________________ Intake assessment completed by: ____________________________

Dated: _________________ Reviewed by Supervisor: _________________________________

Supervisor recommends: □ Assigned to MFT Trainee with no stipulations
☐ Assigned to MFT Trainee with stipulations (see below)
☐ Client to be referred out due to: ______________________________________________________________________

STATUS OF INTAKE ASSESSMENT

☐ Client to be seen at this Clinic Assigned to: ________________________________

☐ Client to be assigned to this Clinic with stipulation(s) as follows:
1. __________________________________________________________________________
2. __________________________________________________________________________
3. __________________________________________________________________________

☐ Client to be referred out to the community. Referrals given as follows:
1. __________________________________________________________________________
2. __________________________________________________________________________
3. __________________________________________________________________________

Dated: _____________________ Center Director
**INTAKE SUMMARY**  □  **TREATMENT SUMMARY**  □ (check one)

| Client Name: |  |  |
| Initial Session Date: | Final Session Date: |
| Treatment Modality: | Individual | Total No. of |
| MFT Trainee: |  | Transferred to: |
| Ethnic Identification: |

- □ Alaskan Native  □ Central American  □ Hispanic  □ Multiracial  □ Vietnamese
- □ American Indian  □ Chinese  □ Hmong  □ Other Asian  □ White-Armenian
- □ Asian Indian  □ Ethiopian  □ Japanese  □ Other Pacific Islander  □ White-Central American
- □ Black/African-American  □ Filipino  □ Korean  □ Polynesian  □ White-European
- □ Cambodian  □ Guamanian  □ Laotian  □ Samoan  □ White-Middle Eastern
- □ Caribbean  □ Hawaiian  □ Mexican  □ South American  □ White-Romanian

**PRESENTING COMPLAINT(S)** (include descriptions of the problem, when it first occurred, and what the client has attempted to resolve the problem):


**PSYCHOSOCIAL HISTORY**

<p>| Family of Origin History: (quality of parental and sibling relationships, number of siblings, birth order, significant) |
| Marital and Relationship History: (length of marriage, number and ages of children, divorces) |</p>
<table>
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<tr>
<th>PSYCHOSOCIAL HISTORY (cont.)</th>
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</thead>
<tbody>
<tr>
<td><strong>Developmental History:</strong></td>
</tr>
<tr>
<td>(early development,</td>
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<tr>
<td>life transitions including</td>
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<tr>
<td>deaths, moves, crises)</td>
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<td></td>
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<tr>
<td><strong>Work / Employment History:</strong></td>
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<tr>
<td>(current and previous jobs,</td>
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<tr>
<td>reasons for leaving</td>
</tr>
<tr>
<td>employment)</td>
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<td></td>
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<td><strong>Educational History:</strong></td>
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<tr>
<td>(Highest level of education</td>
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<tr>
<td>achieved, behavioral</td>
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<tr>
<td>problems, achievements)</td>
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<td>(include any military</td>
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<td>service or service of</td>
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<tr>
<td>significant others)</td>
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<td></td>
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<tr>
<td><strong>Other:</strong></td>
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<td>(include information not</td>
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<tr>
<td>directly assessed for</td>
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<tr>
<td>above, but which may be</td>
</tr>
<tr>
<td>important for</td>
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</tbody>
</table>
### MENTAL HEALTH HISTORY

#### Current psychotropic medications:
- [ ] None
- [ ] (List meds/dosages):

#### Prescribed by:
- [ ] Psychiatrist: Name:
- [ ] Physician: Name:

#### Previous therapy:
- [ ] None reported
- [ ] Frances Smith Center for Individual and Family Therapy (see previous treatment summary)
- [ ] Approximate date(s), focus of therapy, and satisfaction:

#### Psychiatric Hospitalization(s):
- [ ] None reported
- [ ] Yes: Include approx. dates, voluntary or involuntary, and reason

#### History of Suicidal Ideation/Attempt(s):
- [ ] None reported
- [ ] Ideation only (state)
- [ ] Suicide Attempts: (state when/means)

#### History of Substance abuse/dependence
- [ ] None reported
- [ ] Abuse only: (Specify types and duration)
- [ ] Dependence: (Specify types and duration)

#### Family History of Mental Illness:
- [ ] None reported
- [ ] Yes: (identify who and illness, if known)

#### Criminal / Legal History:
- [ ] None reported
- [ ] Yes: (examples may include DUI, custody arrangements, domestic violence, etc.)
ASSessment / Testing

No psychological testing was done.

Testing was done as follows:

<table>
<thead>
<tr>
<th>Test</th>
<th>Date: See Below</th>
<th>Pre-Tx</th>
<th>Mid-Tx</th>
<th>Post-Tx</th>
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<tr>
<td>Outcome Questionnaire 45.2</td>
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<tr>
<td>Beck Depression Inventory-II</td>
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<tr>
<td>Beck Hopelessness Scale</td>
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<td>Dyadic Adjustment Scale</td>
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<td>Date:</td>
<td>No. of</td>
<td>Symptoms:</td>
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<tr>
<td>Marital Satisfaction Inventory-Rev</td>
<td>Date:</td>
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<tr>
<td>Other:</td>
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Summary of Test Results:

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<tr>
<th>Test</th>
<th>Date</th>
<th>Date</th>
<th>Change in Score</th>
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<tbody>
<tr>
<td>OQ-45-2</td>
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<td></td>
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<tr>
<td>Total Score (Total &gt;63 = Dysfunctional)</td>
<td>Total =</td>
<td>Total =</td>
<td>Improved (Decrease 14+ pts)</td>
</tr>
<tr>
<td>Symptom Distress (SD &gt; 36 = Dysfunctional)</td>
<td>SD =</td>
<td>SD =</td>
<td>Improved (Decrease 10+ pts)</td>
</tr>
<tr>
<td>Interpersonal Relationship (IR &gt; 15 = Dysfunctional)</td>
<td>IR =</td>
<td>IR =</td>
<td>Improved (Decrease 8+ pts)</td>
</tr>
<tr>
<td>Social Role (SR &gt; 12 = Dysfunctional)</td>
<td>SR =</td>
<td>SR =</td>
<td>Improved (Decrease 7+ pts)</td>
</tr>
<tr>
<td>Critical Items:</td>
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<tr>
<td>Suicide (#8)</td>
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<tr>
<td>Substance Abuse (#11,26,32)</td>
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<tr>
<td>Violence at work (#44)</td>
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0=Never 3=Frequently 1=Rarely 4=Almost Always 2=Sometimes
### Treatment Considerations from Test Results:

---

### DIAGNOSIS

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<th>CODE</th>
<th>DIAGNOSIS</th>
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Diagnostic Summary (include specific symptoms, course, intensity, and impacts to life domains):

---

### SYSTEMIC CONCEPTUALIZATION/TREATMENT PLAN:

Systemic Case Conceptualization (summarize your understanding of the most relevant factors explaining the client’s complaint(s)):
TREATMENT PLAN:

A) List between 1 and 3 specific and measurable goals, B) List a general treatment approach (i.e., Bowenian, CBT, ACT, IPT, EFT, TBCT, ICBT), c) List primary techniques you will use to accomplish treatment goals (i.e., genogram, communication skills, mindfulness, desensitization, tracking negative cycles, behavior exchange, empathic joining)

<table>
<thead>
<tr>
<th>General Approach:</th>
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<tbody>
<tr>
<td>Goal 1:</td>
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<td>Goal 2:</td>
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<tr>
<td>Goal 3:</td>
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<tr>
<td>Technique:</td>
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<tr>
<td>Technique:</td>
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<tr>
<td>Technique:</td>
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</tbody>
</table>

CLIENT CENTERED ADVOCACY / REFERRALS:

- [ ] No referrals made
- [ ] Psychiatric evaluation
- [ ] Medical evaluation
- [ ] Substance abuse
- [ ] Other: (specify)

Support group: [ ]
Psychoeducational: [ ]
Legal: [ ]
Psychological testing: [ ]

INTAKE SIGNATURES

Date: ____________  Signature: ________________________________
* MFT Trainee

Date: ____________  Signature: ________________________________
* LMFT, Clinical Supervisor
MENTAL STATUS AND HISTORY

CLIENT NAME: 

DATE OF OBSERVATION: 

MFT TRAINEE: 

APPEARANCE:

<table>
<thead>
<tr>
<th>Present</th>
<th>Absent</th>
<th>No Data</th>
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<tbody>
<tr>
<td>UNKEMPT, UNCLEAN, DISHEVELED</td>
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<tr>
<td>CLOTHING AND/OR GROOMING ATYPICAL</td>
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<tr>
<td>UNUSUAL PHYSICAL CHARACTERISTICS</td>
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</table>

COMMENTS RE: APPEARANCE:

BEHAVIOR:

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<thead>
<tr>
<th>Present</th>
<th>Absent</th>
<th>No Data</th>
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<tbody>
<tr>
<td>POSTURE: SLUMPED</td>
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<tr>
<td>RIGID, TENSE</td>
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<tr>
<td>FACIAL EXPRESSION SUGGESTS: ANXIETY, FEAR, APPREHENSION</td>
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<tr>
<td>DEPRESSION, SADNESS</td>
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<tr>
<td>ANGER, HOSTILITY</td>
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<tr>
<td>ABSENCE OF FEELINGS, BLANDNESS</td>
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<td></td>
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<tr>
<td>ATYPICAL, UNUSUALNESS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GENERAL BODY MOVEMENTS: ACCELERATED, INCREASED SPEED</td>
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<td></td>
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<tr>
<td>DECREASED, SLOWED</td>
<td></td>
<td></td>
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<tr>
<td>ATYPICAL, UNUSUAL</td>
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<td></td>
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<tr>
<td>RESTLESSNESS, FIDGETINESS</td>
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<td>SPEECH: RAPID SPEECH</td>
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<tr>
<td>SLOWED SPEECH</td>
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<td>LOUD SPEECH</td>
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<td>SOFT SPEECH</td>
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<tr>
<td>MUTE</td>
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<tr>
<td>ATYPICAL QUALITY, SLURRING, STAMMER</td>
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THERAPIST-CLIENT RELATIONSHIP: DOMINEERING, CONTROLLING

<table>
<thead>
<tr>
<th>Present</th>
<th>Absent</th>
<th>No Data</th>
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<tbody>
<tr>
<td>SUBMISSIVE, OVERLY COMPLIANT</td>
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<tr>
<td>PROVOCATIVE, HOSTILE, CHALLENGING</td>
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<tr>
<td>SUSPICIOUS, GUARDED, EVASIVE</td>
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<tr>
<td>UNCOOPERATIVE, NON-COMPLIANT</td>
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COMMENTS RE: BEHAVIOR:
**FEELING, AFFECT, AND MOOD:**

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<tr>
<th>Present</th>
<th>Absent</th>
<th>No Data</th>
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<tbody>
<tr>
<td>INAPPROPRIATE TO THOUGHT CONTENT</td>
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<tr>
<td>INCREASED LABILITY OF AFFECT</td>
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<tr>
<td>PREDOMINANT MOOD IS BLUNTED, DULL, BLAND</td>
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<tr>
<td>PREDOMINANT MOOD IS EUPHORIA, ELATION</td>
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<tr>
<td>PREDOMINANT MOOD IS ANGER, HOSTILITY</td>
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<tr>
<td>PREDOMINANT MOOD IS ANXIETY, FEAR, APPREHENSION</td>
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<tr>
<td>PREDOMINANT MOOD IS DEPRESSION, SADNESS</td>
<td></td>
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<tr>
<td>COMMENTS RE: FEELING, AFFECT, AND MOOD:</td>
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**PERCEPTION:**

<table>
<thead>
<tr>
<th>Illusions</th>
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<tr>
<td>Auditory Hallucinations</td>
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<tr>
<td>Visual Hallucinations</td>
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<tr>
<td>Other Type of Hallucination</td>
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</tbody>
</table>

**THOUGHTS:**

| Impaired Level of Consciousness | | |
| Impaired Attention Span/Distracted | | |
| Impaired Abstract Thinking | | |
| Impaired Calculation Ability | | |
| Impaired Intelligence | | |

**ORIENTATION:**

| Disoriented to Person | | |
| Disoriented to Place | | |
| Disoriented to Time | | |

**MEMORY:**

| Impaired Recent Memory | | |
| Impaired Remote Memory | | |

**INSIGHT:**

| Denies Presence of Psychological Problems | | |
| Impaired Remote Memory | | |

**JUDGMENT:**

| Impaired Ability to Make Routine Decisions | | |
| Impaired Impulse Control | | |

**THOUGHT CONTENT:**

| Obsessions | | |
| Compulsions | | |
| Phobias | | |
| Depersonalizations | | |
| Suicidal Ideation | | |
| Homicidal Ideation | | |
| Delusions | | |

**STREAM OF THOUGHT:**

| Associational Disturbance | | |

**COMMENTS RE: THINKING:**

| | | |
| | | |
**LICENSED MARRIAGE AND FAMILY THERAPIST**  
**IN-STATE EXPERIENCE VERIFICATION**  
**OPTION 1 – STREAMLINED METHOD**

This form is to be completed by the applicant's California supervisor and submitted by the applicant with his or her Application for Licensure and Examination. All information on this form is subject to verification.

- Use this "Option 1" form to report hours under the streamlined method
- Use separate forms for pre-degree and post-degree experience
- Use separate forms for each supervisor and each employment setting
- Ensure that the form is complete and correct prior to signing
- Provide an original signature and have the supervisor initial any changes
- Do not submit Weekly Summary forms unless specifically requested

### APPLICANT NAME:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Associate Number</th>
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### SUPERVISOR INFORMATION:

<table>
<thead>
<tr>
<th>Supervisor's Last Name</th>
<th>First</th>
<th>Middle</th>
<th>Business Phone</th>
<th>Email Address (OPTIONAL)</th>
</tr>
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<tr>
<th>License Type</th>
<th>License Number</th>
<th>State</th>
<th>Date First Licensed</th>
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- **Physicians:** Were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision?  
  - [ ] N/A  
  - [ ] No  
  - [ ] Yes: Date Certified: ___________  
  - Cert. #: ____________

- **LPCCs:** Did you meet the qualifications to treat couples and families during the entire period of supervision, as specified in California law?  
  - [ ] N/A  
  - [ ] No  
  - [ ] Yes: Date you met the qualifications: _________________

### APPLICANT’S EMPLOYER INFORMATION:

<table>
<thead>
<tr>
<th>Name of Applicant’s Employer</th>
<th>Business Phone</th>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Number and Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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</table>
**EMPLOYER INFORMATION (continued):**

1. Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy?  
   - [ ] Yes  [ ] No

2. Was this experience gained in a private practice setting?  
   - [ ] Yes  [ ] No

3. Was this experience gained in a setting that provided oversight to ensure that the applicant’s work meets the experience and supervision requirements and is within the scope of practice?  
   - [ ] Yes  [ ] No

4. For hours gained as an Associate ONLY: Was the applicant receiving pay?  
   - [ ] Yes  [ ] No
   
   *If YES, attach a copy of the applicant’s W-2 statement for each year experience is claimed. If a W-2 has not yet been issued for this year, attach a copy of the current paystub. If applicant volunteered, submit a letter from the employer verifying volunteer status.*

**EXPERIENCE INFORMATION:**

<table>
<thead>
<tr>
<th>1. Dates of experience being claimed:</th>
<th>From: mm/dd/yyyy</th>
<th>To: mm/dd/yyyy</th>
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</table>

2. How many weeks of supervised experience are being claimed? __________ weeks

3. Hours of Experience:  
   a. Total Direct Counseling Experience (Minimum 1,750 hours)
   
   - Of the above hours, how many were gained diagnosing and treating Couples, Families and Children? (Minimum 500 of the 1,750 hours)

   b. Total Non-Clinical Experience (Maximum 1,250 hours)
   
   - Of the above hours, how many were Face-to-Face Supervision?  
     
     | Hours Per Week | Logged Hours |
     |---------------|--------------|
     | Individual or Triadic | |
     | Group (group contained no more than 8 persons) | |

**NOTE:** Knowingly providing false information or omitting pertinent information may be grounds for denial of the application. The Board may take disciplinary action on a licensee who helps an applicant obtain a license by fraud, deceit or misrepresentation.

Signature of Supervisor: __________________________ Date: __________

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SEMESTER: 

FRANCES SMITH CENTER FOR INDIVIDUAL AND FAMILY THERAPY

MFT TRAINEE INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>Home Phone: ( )</th>
<th>Address:</th>
<th>Cell Phone: ( )</th>
<th>Email:</th>
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</table>

Chapman ID No.:  | DOB:  | Age:  | Gender: |
|-----------------|-------|-------|---------|

- [ ] Alaskan Native
- [ ] American Indian
- [ ] Asian Indian
- [ ] Black/African-American
- [ ] Cambodian
- [ ] Caribbean
- [ ] Central American
- [ ] Chinese
- [ ] Filipino
- [ ] Guamanian
- [ ] Hawaiian
- [ ] Hispanic
- [ ] Hmong
- [ ] Japanese
- [ ] Korean
- [ ] Laotian
- [ ] Mexican
- [ ] Multiracial
- [ ] Other Asian
- [ ] Other Pacific Islander
- [ ] Polynesian
- [ ] Samoan
- [ ] South American
- [ ] Vietnamese
- [ ] White-Armenian
- [ ] White-Central American
- [ ] White-European
- [ ] White-Middle Eastern
- [ ] White-Asian Indian
- [ ] White-Asian Indian
- [ ] White-Cambodian
- [ ] White-Black/African-American
- [ ] White-Black/African-American
- [ ] White-Bilingual skills (i.e., fluent and able to do therapy in second language):
- [ ] None
- [ ] Yes: Specify language(s): ______________________________________________________

Religious background: (In the event a client requests a therapist familiar with his/her religion): ______________________________________________________

Previous counseling experience during the last 5 years:  
- [ ] None
- [ ] Volunteer
- [ ] Job

If “volunteer” or “job” is checked, please describe below (where, what population, when): ______________________________________________________

Approximate number of hours of face-to-face counseling to date: ______________________________________________________

Special training, licenses, or workshops you have attended: ______________________________________________________

Most experienced with certain age groups, types of problems/clients:  
-____________________________________________________
-____________________________________________________
-____________________________________________________

Therapeutic orientation: ______________________________________________________
NO VIOLENCE SAFETY AGREEMENT

Client Name: ___________________________________________

MFT Trainee: __________________________________________

When treating clients where violence has been present, our primary goal at the Frances Smith Center for Individual and Family Therapy (“Center”) is to ensure our clients’ safety. This agreement represents the first step in accomplishing this goal. In addition to this agreement, we may also teach you about safety planning, conduct pre-/post-session checks, teach negotiated time-out techniques, and refer you to anger management classes if needed. If the terms of this agreement are broken, a referral will be given to clients for services at a more appropriate venue.

I, ___________________________, agree not to use any physical violence towards my partner during the time we are in therapy together at the Center. Violence is defined as hitting, kicking, biting, throwing objects, scratching, pushing, or excessive yelling and name calling. Violence may also include:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

I understand that my spouse will develop a safety plan as a way to protect her/himself in the case where I threaten violence by action or word. Her/his actions of protection will not cause me to threaten or be violent.

When I feel as though I may become violent I will utilize the following strategies:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

If I become violent at any time, I understand that couples therapy will likely be terminated, and that I will receive a referral for appropriate individual services at another agency.

Dated: ___________________________  Signature: ___________________________

Dated: ___________________________  Witness: ____________________________

(REV. 2/20/17)

(ORIGINAL TO CLIENT / MAKE COPY FOR FILE)
OATH OF CONFIDENTIALITY

I, the undersigned, hereby agree not to divulge any information or records concerning any client/patient without proper authorization in accordance with California Welfare and Institutions (W & I) Code, Section 5328, et seq.

I recognize the unauthorized release of confidential information may make me subject to a civil action under provisions of the W&I Code and Title 9, California Administrative Code, as follows:

**W&I Code, section 5330:**

(a) Any person may bring an action against an individual who has willfully and knowingly released confidential information or records concerning him or her in violation of this chapter or of Chapter 1 (commencing with Section 11860) of Part 3 of Division 10.5 of the Health and Safety Code, for the greater of the following amounts:

   (1) Ten thousand dollars ($10,000).
   (2) Three times the amount of actual damages, if any, sustained by the plaintiff.

(b) Any person may bring an action against an individual who has negligently released confidential information or records concerning him or her in violation of this chapter, or of Chapter 1 (commencing with Section 11860) of Part 3 of Division 10.5 of the Health and Safety Code, for both of the following amounts:

   (1) One thousand dollars ($1,000). In order to recover under this paragraph, it shall not be a prerequisite that the plaintiff suffer or be threatened with actual damages. The amount of actual damages, if any, sustained by the plaintiff.

(c) Any person may, in accordance with Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, bring an action to enjoin the release of confidential information or records in violation of this chapter, and may in the same action seek damages as provided in this section.

(d) In addition to the amounts specified in subdivisions (a) and (b), the plaintiff shall recover court costs and reasonable attorney’s fees as determined by the court.

_____________________________  ________________________________
Name (please print)                  Signature, MFT Trainee

_____________________________
Date:                                  Director

(Oath of Confidentiality [Rev. Oct 2015]
PHOTOGRAPHIC CONSENT AND RELEASE

I irrevocably authorize Chapman University (the “University”), its employees, and its agents, to use my name, picture, and likeness as recorded by the University prior to the date of this Release for any purpose that the University deems appropriate, including promotional or advertising efforts. I specifically authorize the University, its employees, and its agents, to use, reproduce, exhibit, or distribute my name and likeness for such purpose in any communications medium currently existing or later created, including without limitation print media, television, and the Internet.

I release the University, its employees, and its agents, either in their individual capacities or by reason of their relationship to the University, from liability for any violation of any personal or proprietary right I may have in connection with the above use. I understand that all recordings of my name, picture, and likeness, in whatever medium, shall remain the property of the University.

I agree to hold harmless and release and forever discharge the University, its employees, and its agents, either in their individual capacities or by reason of their relationship to the University, from all claims and demands whatsoever, even if arising from the negligence of the University, that I or any other persons acting on my behalf or on the behalf of my estate have or may have against the University or any or all of the above-mentioned persons or their successors by reason of the permission effected by this Release.

I represent that I am at least eighteen (18) years of age and have the legal right to sign for myself. I further represent that I have read and understand this document completely before signing it. I agree that I will not revoke or disaffirm this Release at any time.

Name:
Address:
Phone:
Signature: _________________________________________________
Date: 
PRACTICUM REQUIREMENTS FOR MFT TRAINEES

1. You will provide informed consent and obtain signature(s) with all clients prior to the commencement of therapy. Informed consent includes the following: you are an unlicensed MFT trainee, the name of your supervisor, and that you will be discussing his/her/their case with your supervisor as part of supervision.

2. Agree to only provide marriage and family therapy counseling within the scope of your education, training, experience, and supervision.

3. Agree to comply with all BBS regulations and AAMFT/CAMFT Code of Ethics.

4. Agree that you will need to accrue 300 face-to-face hours (of which 120 hours must be relational) over the course of three (3) semesters and interterm in order to graduate from the MFT program. You understand that if you do not accrue these hours, you may be required to complete an additional semester in order to obtain these 300 hours.

5. Agree that you will participate in a minimum of two (2) collaborations during the time you are in the Frances Smith Center. (Collaborations are the following: Balanced Families, Stroke Boot Camp, and the Wooden Floor.)

6. Be on time to therapy appointments and weekly supervision. If you need assistance between regularly scheduled supervision, call your individual supervisor. You are required to attend both group and individual supervision every week, regardless of client hours. Supervision is more than a BBS requirement, it is a class.

7. Agree to maintain good ethical and therapeutic boundaries. This would include, but is not limited to: end sessions on time; collect fees and not allow client(s) to accrue a balance; maintain professional conduct, including compliance with dress code; not engage in any other type of relationship except client-therapist (this includes friendship, having contact out of session, having contact via any social networking format, exchanging personal information including your cell number, meeting with clients anywhere other than in the Center); and any other boundary, implied or otherwise, that would interfere in the therapeutic relationship.

8. Agree to comply with all aspects of the Supervision Contract and procedures set forth in that document. This includes: Inform your individual supervisor immediately of crisis issues such as, but not limited to: suspicion of child or elder abuse, potential suicide, hospitalization, Tarasoff situations, and dangerous clients.
9. Document crisis facts carefully and completely in case notes and review those notes with your individual supervisor. All case notes are to remain in locked files on the premises.

10. All files, case notes, tests, and any other client documents are Center property and are to remain in locked files on the premises.

11. Agree that no other person other than the client (other than parent/guardian for a minor) may enter the therapy session without prior approval of your supervisor.

12. Any change in modality of service must be discussed and approved by your individual supervisor before any change can be made.

13. Prior to the transfer of any client to another trainee, you must discuss and get the approval of your individual supervisor.

14. Progress notes must be completed within 24 hours of session.

15. A preliminary treatment plan and diagnosis must be initiated and submitted to your individual supervisor within 4 weeks from the initial session date.

16. Complete termination summaries must be submitted to your individual supervisor within two weeks of final session.

17. Agree to give evaluations, assessments, and any other measures as instructed by your individual supervisor or Center administration.

18. Agree to check your voicemail messages a minimum of twice a day during the week, and once a day on weekends. In addition, should you go on vacation, you agree to have another trainee check your messages regularly. With any planned absence, you will notify Center staff as well as the answering service who will be on call for you, as well as your return date.

19. Adhere to the room scheduling procedures and writing of receipts as outlined in orientation.

20. Show your individual supervisor ALL written correspondence you receive or intend to send before you send it.

21. Ensure that all written correspondence must have your name and title (MFT Trainee), and either your supervisor’s signature and license number, or the Clinic Director’s signature, title, and license number. NO CORRESPONDENCE MAY BE SENT WITHOUT YOUR SUPERVISOR’S SIGNATURE OR THE SIGNATURE OF THE ASSOCIATE DIRECTOR.

22. Prepare BBS “Weekly Hours of Experience” log for weekly signature by individual supervisor, as well as the Monthly Activity Report.

23. Agree to record all client sessions for your supervisor, and delete sessions once they have been reviewed by your supervisor (except for those you will need for your Capstone Project).

24. Read and sign the notice regarding child abuse and dependent adult/elder abuse reporting law and oath of confidentiality.

25. Attend staff development meetings and mandatory in services.
26. Request vacation and time off during the semester in writing according to current Center guidelines and forms.

27. Agree to maintain the premises in its present condition, normal wear and tear excepted. You agree to leave counseling rooms in order for the next therapist, clean-up after use of child therapy materials, sand tray, or art work.

I HAVE READ, FULLY UNDERSTAND, AND AGREE TO THESE CONDITIONS OF MY PRACTICUM AS A MARRIAGE AND FAMILY THERAPIST TRAINEE. I UNDERSTAND THAT FAILURE TO FOLLOW THESE REQUIREMENTS MAY RESULT IN MY FAILURE TO PASS PRACTICUM AND/OR REMOVAL FROM THE MFT PROGRAM AT CHAPMAN UNIVERSITY.

Name: ____________________________________________

Print Name

Signature: _______________________________ Date: _________________

Clinic Director: _______________________________ Date: _________________
The purpose of this call is to confirm the information provided by the client, as well as gather some additional information. I have a signed release and I have mailed (or faxed) it to your office on ______ ________ (date).

The client has been in therapy with me since ________________________________(date).

What medication(s) are you prescribing and what is the dosage for each?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
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What is the diagnosis you have given to the client?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Is there any information that you think I should know that would be helpful to the client’s therapy? (Document any other information provided by or requested by the physician as part of the telephone consultation):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Dated: ____________________________

MFT Trainee

PSYCHIATRIC CONSULT NOTE
MAKING AN APPOINTMENT WITH A PSYCHIATRIST

PSYCHIATRIC REFERRAL

What is a psychiatrist?
Psychiatrists are physicians, and as such may prescribe medication. After completing medical school, they specialize in the treatment of emotional, mental, and behavioral problems. The Frances Smith Center may refer to a number of local psychiatrists to evaluate clients who are having difficulty functioning in daily routines. Costs may be partially or fully covered through your insurance. Please contact your insurance company to verify your benefits (call the toll-free number listed as customer service on your insurance card).

Evaluation Appointment with the Psychiatrist
During the appointment, the psychiatrist will ask about your history and current concerns. At the end of the meeting, he/she will make recommendations based on information received from your therapist and during the meeting with you. One recommendation may be for you to try medication in an effort to help you cope more effectively with your circumstances. During your appointment with the psychiatrist, be sure to discuss the recommendations and ask any questions you may have about the medication. The medication is a recommendation, you have the right to choose if you will begin to take it or not. The psychiatrist may have some free medication samples that will help you get started; however, you will need to fill the prescription at your own expense or use your health insurance plan. Please have your psychiatrist give you a release form that you can sign allowing your psychiatrist to discuss findings with your therapist.

Additional Appointments
If you choose to take the medication, one or two follow-up visits with the psychiatrist will be necessary to ensure that the medication(s) are working effectively and that you are not having any problems with side effects. During these appointments, discuss concerns you have regarding your coping skills, circumstances, and medication, including any changes you have noticed that might be an unwanted side effect. Some medications require a blood test or other lab work. The psychiatrist will let you know if this is the case for any medication that you are taking.

Referrals
It is important to know whether you have insurance coverage that may cover all or part of the cost of a psychiatrist and medication. Please see the reverse side of this form and answer the questions listed. This should help you to determine (1) whether or not you have insurance coverage; (2) how to access a psychiatrist through your insurance; or (3) you have no insurance coverage, so what are some low cost options within Orange County.

Coordination of care between your therapist and your psychiatrist
As a part of treatment, it is important that your therapist and your psychiatrist be able to talk to one another in order to coordinate your care. Your therapist will ask you to sign a release of information allowing the exchange of information between them. Generally, the information shared will include such things as the medication(s) and dosage that you have been prescribed, as well as diagnostic information important to your treatment plan. If you have any other questions about this, please speak with your therapist.
REVIEW THE FOLLOWING CHECKLIST WITH YOUR CLIENT WHEN MAKING A PSYCHIATRIC REFERRAL:

1. **DO YOU HAVE MEDICAL COVERAGE (either group insurance thru employer or a private policy)?**
   - YES: Refer to customer service number located on the insurance card to determine how to access mental health coverage (psychiatrist)
   - NO: Proceed to Question #2.

2. **DO YOU HAVE KAISER INSURANCE?**
   - YES: Kaiser Behavioral Health, 1900 E. 4th St., Santa Ana, CA 92705 (714-667-6069)
   - NO: Proceed to Question #3.

3. **DO YOU HAVE MEDICARE INSURANCE?**
   - YES: Call the O.C. Psychiatric Society at (714) 978-3016 (M-F, 1:00 to 5:00 pm) and ask for names of psychiatrists that accept Medicare.
   - NO: Proceed to Question #4.

4. **DO YOU HAVE MEDI-CAL, CAL OPTIMA, OR HEALTHY FAMILIES COVERAGE?**
   - YES: Call 800-723-8641 and complete a brief telephone screening. Based on the information given:
     - For Medi-Cal and Healthy Families, you will be given an authorization number and the name/telephone number of a provider.
     - For CalOptima, you may be referred to the CalOptima line where you will be given several referrals to authorized providers.
   - NO: Proceed to Question #5.

5. **DO YOU HAVE A SUBSTANCE ABUSE (CO-OCCURRING) DISORDER?**
   - YES: Call OC LINKS at 855-625-4657 to see if there are County programs OR the Addiction Treatment Center (714-992-1677) who will refer to MHA for psych evaluation.
   - NO: Proceed to Question #6.

6. **ARE YOU CURRENTLY A COLLEGE STUDENT?**
   - YES: Contact the Student Health Center and ask if they have a psychiatrist on staff, or their medical doctor is willing to prescribe psych meds.
   - NO: Proceed to Question #7.

7. **DO YOU HAVE SOME FINANCIAL ABILITY TO PAY FOR AN EVALUATION?**
   - YES: Listed below are a few lower cost options:
     - UCI (714-456-05902): Provided by Residents: $150 for initial eval; $100 for follow-up med checks
     - Look at low cost medical clinics who may be willing to prescribe psych meds
   - NO: TALK TO YOUR SUPERVISOR OR CLINIC DIRECTOR

**WHAT ARE OPTIONS FOR ASSISTANCE WITH THE COST OF MEDICATIONS IF THERE IS NO INSURANCE COVERAGE?**
- If medication has a generic, call around pharmacies for lowest cost (check Walmart as well)
- Ask the prescribing doctor’s office if they can help client apply to a PAP (Prescription Assistance Program) for help with lowering the cost of the medication (e.g., RXHope, etc.)
- Ask prescribing physician if he/she can provide initial samples of the medication that are free of charge
PURPOSE OF FORM
This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult. Abuse means any treatment with resulting physical harm, pain, or mental suffering or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. Neglect means the negligent failure of an older or dependent adult or of any person having the care or custody of an older or a dependent adult to exercise that degree of self-care or care that a reasonable person in a like position would exercise. Elder means any person residing in the state who is 65 years of age or older (WIC Section 15610.27). Dependent Adult means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM
1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES AND TIME FRAMES:
Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect has occurred, shall complete this form for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

*Serious bodily injury means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).*

Reporting shall be completed as follows:
- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury, report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practically possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.
• If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential Internet reporting tool (established in WIC Section 16656) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:
  • If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.
  • If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.
  • For all other abuse, mandated reporters shall report by telephone or through a confidential Internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or oral report shall be sent to adult protective services or law enforcement within two working days.

REPORTING PARTY DEFINITIONS

Mandated Reporter (WIC Section 15600) (a) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.

Care Custodian (WIC Section 15610.17) means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code; (b) Clinics; (c) Home health agencies; (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services; (e) Adult day health care centers and adult day care; (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders; (g) Independent living centers; (h) Camps; (i) Alzheimer Disease Care Resource Centers; (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 15692 of the Health and Safety Code; (k) Respite care facilities; (l) Foster homes; (m) Vocational rehabilitation facilities and work activity centers; (n) Designated area agencies on aging; (o) Regional centers for persons with developmental disabilities; (p) State Department of Social Services and State Department of Health Services licensing divisions; (q) County welfare departments; (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys; (s) The Office of the State Long-Term Care Ombudsman; (t) Offices of public conservators, public guardians, and court investigators; (u) Any protection or advocacy agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities; or (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness; (v) Humane societies and animal control agencies; (w) Fire departments; (x) Offices of environmental health and building code enforcement; or (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults.

Health Practitioner (WIC Section 15610.37) means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor registered under Section 4808.44 of the Business and Professions Code, state or county public health or social services employee who treats an elder or a dependent adult for any condition, or a coroner.

Any officer and/or employee of a financial institution is a mandated reporter of suspected financial abuse and shall report suspected financial abuse of an elder or dependent adult on form SOC 342, “Report of Suspected Dependent Adult/Elder Financial Abuse”.

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.
IDENTITY OF THE REPORTER
The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Procurate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

FAILURE TO REPORT
Failure to report by mandated reporters (as defined under “Reporting Party Definitions”) any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine (WIC Section 15630(h)).

Officers or employees of financial institutions are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter, to the party bringing the action.

EXCEPTIONS TO REPORTING
Per WIC Section 15630(b)(3)(A), a mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

1. The mandated reporter has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).
2. The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
3. The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
4. In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

DISTRIBUTION OF SOC 341 COPIES
Mandated reporter: After making the telephone report to the appropriate agency or agencies, the reporter shall send the written report to the designated agencies (as defined under “Reporting Responsibilities and Time Frames”); and keep one copy for the reporter’s file.

Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable. DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS DIVISION.
Client Name: _______________________________

RESEARCH AGREEMENT

As a training facility, the Frances Smith Center for Individual and Family Therapy supports the advancement of understanding healthy relationships and human functioning by encouraging worthy research projects by students and faculty at Chapman University. There are two ways in which research information (data) can be gathered in the clinic.

1. Participation by clients in research projects
2. Review of client records

CLIENT PARTICIPATION

I understand that I might be asked to participate in a research project. I understand that I will be given a written consent form which will explain the purpose of the project and my participation. Participation is voluntary. I further understand that my treatment at the Frances Smith Center is not affected by my decision to participate or not participate in the research project.

REVIEW OF RECORDS

I understand that my records at the Frances Smith Center may be utilized for research purposes. My anonymity will be protected because the information gathered will only be reported as group information. I further understand that if I do not wish for my records to be included, the Clinic Director/Associate Director will ensure that any research conducted utilizing client records will not include mine. My treatment at the Frances Smith Center will not be affected by my decision regarding this matter.

☐ I voluntarily give my consent to the possible use of my records for research.

☐ I refuse to give my consent to the possible use of my records for research.

Dated: __________________________

_______________________________
Signature of Client (or Parent/Guardian)

_______________________________
Marriage and Family Therapist Trainee (MFT Trainee)

_______________________________
Clinic Director
RESPONSIBILITY STATEMENT FOR SUPERVISORS
OF A MARRIAGE AND FAMILY THERAPIST TRAINEE OR INTERN

Title 16, California Code of Regulations (16 CCR) section 1833.1 requires any qualified licensed mental health professional who assumes responsibility for providing supervision to those working toward licensure as a Licensed Marriage and Family Therapist to complete and sign, under penalty of perjury, the following statement prior to the commencement of any counseling or supervision, and to provide the associate or trainee with the original.

<table>
<thead>
<tr>
<th>Name of MFT Trainee/Intern:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
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<tbody>
<tr>
<td>Name of Qualified Supervisor:</td>
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| Qualified Supervisor's Daytime Telephone Number: |

As the supervisor:

1) I am licensed in California and have been so licensed for at least two years prior to commencing this supervision. (16 CCR § 1833.1(a)(1) and Business and Professions Code (BPC) § 4999.12 (h))

A. The license I hold is:

- [ ] Licensed Marriage and Family Therapist
- [ ] Licensed Clinical Social Worker
- [ ] Licensed Professional Clinical Counselor
- [ ] Licensed Psychologist
- [ ] Physician certified in psychiatry by the American Board of Psychiatry and Neurology

<table>
<thead>
<tr>
<th>License #</th>
<th>Issue Date</th>
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B. **I have had sufficient experience, training, and education in marriage and family therapy to competently practice marriage and family therapy in California.** (16 CCR § 1833.1(a)(2))

C. I will keep myself informed about developments in marriage and family therapy and in California law governing the practice of marriage and family therapy. (16 CCR § 1833.1(a)(3))

2) I have and maintain a current and valid license in good standing and will immediately notify any trainee or intern under my supervision of any disciplinary action taken against my license, including revocation or suspension, even if stayed, probation terms, inactive license status, or any lapse in licensure, that affects my ability or right to supervise. (16 CCR § 1833.1(a)(1), (a)(4))

3) I have practiced psychotherapy or provided direct supervision of trainees, interns, associate clinical social workers, or professional clinical counselor interns who perform psychotherapy for at least two (2) years within the five (5) year period immediately preceding this supervision. (16 CCR § 1833.1(a)(5))

4) I have had sufficient experience, training, and education in the area of clinical supervision to competently supervise trainees or interns. (16 CCR § 1833.1(a)(6))

5) I have completed six (6) hours of supervision training or coursework within the renewal period immediately preceding this supervision, and must complete such coursework in each renewal period while supervising. If I have not completed such training or coursework, I will complete a minimum of six (6) hours of supervision training or coursework within sixty (60) days of the commencement of this supervision, and in each renewal period while providing supervision. (16 CCR § 1833.1(a)(6)(A)&(B))
6) I know and understand the laws and regulations pertaining to both the supervision of trainees and interns and the experience required for licensure as a marriage and family therapist. (16 CCR § 1833.1(a)(7))

7) I shall ensure that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the trainee or intern. (16 CCR § 1833.1(a)(8))

8) I shall monitor and evaluate the extent, kind, and quality of counseling performed by the trainee or intern by direct observation, review of audio or video tapes of therapy, review of progress and process notes and other treatment records, or by any other means deemed appropriate. (16 CCR § 1833.1(a)(9))

9) I shall address with the trainee or intern the manner in which emergencies will be handled. (16 CCR § 1833.1(a)(10))

10) I agree not to provide supervision to a TRAINEE unless the trainee is a volunteer or employed in a setting that meets all of the following: (A) lawfully and regularly provides mental health counseling or psychotherapy; (B) provides oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements and is within the scope of practice for the profession as defined in BPC Section 4980.02; (C) is not a private practice owned by a licensed marriage and family therapist, a licensed psychologist, a licensed clinical social worker, a licensed physician and surgeon, or a professional corporation of any of those licensed professions. (BPC § 4980.43(d)(1))

11) I agree not to provide supervision to an INTERN unless the intern is a volunteer or employed in a setting that meets both of the following: (A) lawfully and regularly provides mental health counseling or psychotherapy; (B) provides oversight to ensure that the intern's work at the setting meets the experience and supervision requirements and is within the scope of practice for the profession as defined in BPC Section 4980.02. (BPC § 4980.43(e)(1))

12) If I am to provide supervision on a voluntary basis in a setting which is not a private practice, a written agreement will be executed between myself and the organization in which the employer acknowledges that they are aware of the licensing requirements that must be met by the intern or trainee, they agree not to interfere with my legal and ethical obligations to ensure compliance with these requirements, and they agree to provide me with access to clinical records of the clients counseled by the intern or trainee. (16 CCR § 1833(b)(4))

13) I shall give at least (1) one week's prior written notice to a trainee or intern of my intent not to sign for any further hours of experience for such person. If I have not provided such notice, I shall sign for hours of experience obtained in good faith where I actually provided the required supervision. (16 CCR § 1833.1(c))

14) I shall obtain from each trainee or intern for whom supervision will be provided, the name, address, and telephone number of the trainee’s or intern’s most recent supervisor and employer. (16 CCR § 1833.1(d))

15) In any setting that is not a private practice, I shall evaluate the site(s) where a trainee or intern will be gaining hours of experience toward licensure and shall determine that: (1) the site(s) provides experience which is within the scope of practice of a marriage and family therapist; and (2) the experience is in compliance with the requirements set forth in 16 CCR Section 1833 and Section 4980.43 of the Code. (16 CCR § 1833.1(e))

16) Upon written request of the Board, I shall provide to the board any documentation which verifies my compliance with the requirements set forth in 16 CCR Section 1833.1. (16 CCR § 1833.1(f))

17) I shall provide the intern or trainee with the original of this signed statement prior to the commencement of any counseling or supervision. (16 CCR § 1833.1(b))

I declare under penalty of perjury under the laws of the State of California that I have read and understand the foregoing and that I meet all criteria stated herein and that the information submitted on this form is true and correct.

Printed Name of Qualified Supervisor ___________________________ Signature of Qualified Supervisor ___________________________ Date __________

Mailing Address: Number and Street ___________________________ City ___________________________ State ___________ Zip Code __________

THE SUPERVISOR SHALL PROVIDE THE ASSOCIATE OR TRAINEE BEING SUPERVISED WITH THE ORIGINAL OF THIS SIGNED STATEMENT PRIOR TO THE COMMENCEMENT OF ANY COUNSELING OR SUPERVISION.

THE TRAINEE OR ASSOCIATE SHALL SUBMIT THIS FORM TO THE BOARD UPON APPLICATION FOR LICENSURE.
SAFETY PLAN

I, ____________________________, will not take any action to physically harm or kill myself, harm others, or use substances in an effort to escape from or cope with emotions while I am receiving counseling from the Frances Smith Center for Individual and Family Therapy ("Center"). I want to find a more constructive way to deal with the anger and pain that I experience. I will work in therapy to learn constructive alternatives to self-harm or harm others and learn better ways to reduce my emotional distress.

In the event that I feel the desire to hurt myself or another, I will immediately take one or more of the following actions:

A relaxation technique: ________________________________________________________________

____________________________________________________

Some physical activities: ______________________________________________________________

____________________________________________________

____________________________________________________

Where I can go to reduce an immediate stressor: __________________________________________

People who I can call include:

<table>
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<tr>
<th>Name(s)</th>
<th>Telephone Number(s)</th>
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Crisis hotline(s): ________________________________________________________________

The one thing that is most important to me and worth living for is:

____________________________________________________

In an emergency I will call 9-1-1 or go to the nearest Emergency Room.

I agree to abide by this safety agreement either until it expires or it is openly renegotiated with my therapist. I understand it is renewable on ____________________________

(date)

Signature of Client ___________________________ Signature of MFT Trainee ___________________________

Dated: ___________________________

(REV. 2/20/17)

(ORIGINAL TO CLIENT / MAKE COPY FOR FILE)
## SESSION NOTES

<table>
<thead>
<tr>
<th>Name:</th>
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<th>Session No.:</th>
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<table>
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<th>Crisis Management</th>
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* *, MFT Trainee (Signature)
### CPT Codes

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<tr>
<td>90791</td>
<td>Diagnostic Interview (Adult)</td>
</tr>
<tr>
<td>90834</td>
<td>Individual Therapy (38-52 Min)</td>
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<tr>
<td>90847</td>
<td>Family/Conjoint Therapy</td>
</tr>
<tr>
<td>96100</td>
<td>Psychological Testing</td>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for Crisis (1st 60 Min)</td>
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<tr>
<td>90812</td>
<td>Play Therapy (45-50 Min)</td>
</tr>
<tr>
<td>90846</td>
<td>Family/Conjoint (Parent Consult)</td>
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<tr>
<td>90853</td>
<td>Group Psychotherapy</td>
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<tr>
<td>L</td>
<td>Cancellation with 24 Hours Notice</td>
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<tr>
<td>LC</td>
<td>Late Cancellation (Less Than 24 Hrs Notice)</td>
</tr>
<tr>
<td>NS</td>
<td>No Show</td>
</tr>
<tr>
<td>P</td>
<td>Payment Only</td>
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</table>

**Payment Options:**

- **C**: Cancellation with 24 Hours Notice
- **LC**: Late Cancellation (Less Than 24 Hrs Notice)
- **NS**: No Show
- **P**: Payment Only
SOCIAL MEDIA

Social media outlets have exploded in recent years (e.g., Facebook, Instagram, Snapchat, Twitter, Linked In, etc.). As a result, the concept of professional and therapeutic boundaries has become even more important to understand and adhere to. The following questions are posed:

- Where do you draw the line with clients?
- Where does a client's and therapist's privacy end or begin on such sites?
- Public vs. private information
- Who owns the material posted?
- How does this affect one's professional reputation?

Much of this will be litigated in courts and as rulings are made, they will be incorporated into Law and Ethics classes; however, no one wants to be a test case for such a ruling. Therefore, the following rules apply not only during the year you are here at the Center, but also after you leave, as it applies to the Center:

5. You may NEVER “friend” a client – EVER. Even after you graduate from Chapman and the Center, you may not ever “friend” a client that you had here at the Center.

6. If a client does attempt to “friend” you via any social media outlet, you must notify the Center Director immediately.

7. Review any and all Social Media privacy controls to implement the highest level of privacy on your site. You will soon see that this is a small world, and the “six degrees of separation” concept really applies.

8. You may not use Social Media to write or comment on anything related to your caseload, supervision, or anything that might be seen and misconstrued by a client, either current or former. Examples of this include:

- “Had the worst clients today! All they did was argue!”
- “Mary the therapist at the Clinic is horrible.”
- “I can’t believe my supervisor even has a job!”
- “Hope my 6pm client no-shows!”

There are many other examples, but the above gives an idea of the type of inappropriate comments.

9. In addition to comments, you may not take pictures that may include any client-related items or that conveys any sense of casualness or lack of professionalism. For example, a picture of another trainee joking around with a stack of client files next to him/her; or someone sitting at a computer with the computer screen showing an intake summary. **No one may take any pictures inside of the Frances Smith Center other than those approved by the Center Director or other program administration.**

I have read, asked any questions I may have, and agree to abide by the above guidelines. I understand that violation of any of the above may subject me to review by the MFT program administration and may result in my removal from the MFT program without the ability to graduate.

Dated: ____________________________ ____________________________
(Social Media Policy.7/2015) Signature of MFT Trainee
STATEMENT ACKNOWLEDGING REPORTING ABUSE

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSpected ABuSE OF DEPENDENT ADULTS AND ELDERS

NOTE: RETAIN IN EMPLOYEE/ VOLUNTEER FILE

NAME

POSITION

FACILITY

California law REQUIRES certain persons to report known or suspected abuse of dependent adults or elders. As an employee or volunteer at a licensed facility, you are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include care custodians and any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not paid for that responsibility (Welfare and Institutions Code (WIC) Section 15630(a)). Care custodian means an administrator or an employee of most public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff (WIC Section 15610.17).

PERSONS WHO ARE THE SUBJECT OF THE REPORT

Elder means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). Dependent Adult means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age and those admitted as inpatients in 24-hour health facilities (WIC Section 15610.23).

REPORTING RESPONSIBILITIES AND TIME FRAMES

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect occurred, shall complete form SOC 341, "Report of Suspected Dependent Adult/Elder Abuse" for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury (as defined in WIC Section 15610.67), report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in an LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in an LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practicably possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in an LTC facility, and was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.
• If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential Internet reporting tool (established in WIC Section 15658) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:
  • If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.
  • If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.

• For all other abuse, mandated reporters shall report by telephone or through a confidential Internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or an Internet report shall be sent to adult protective services or law enforcement within two working days.

**PENALTY FOR FAILURE TO REPORT ABUSE**

Failure to report abuse of an elder or dependent adult is a MISDEMEANOR CRIME, punishable by jail time, fine or both (WIC Section 15630(h)). The reporting duties are individual, and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report (WIC Section 15630(i)).

**CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS**

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order. Any violation of confidentiality is a misdemeanor punishable by jail time, fine, or both (WIC Section 15633(a)).

**DEFINITIONS OF ABUSE**

**Physical abuse** means any of the following: (a) Assault, as defined in Section 240 of the Penal Code; (b) Battery, as defined in Section 242 of the Penal Code; (c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code; (d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water; (e) Sexual assault, that means any of the following: (1) Sexual battery, as defined in Section 243.4 of the Penal Code; (2) Rape, as defined in Section 261 of the Penal Code; (3) Rape in concert, as described in Section 264.1 of the Penal Code; (4) Spousal rape, as defined in Section 262 of the Penal Code; (5) Incest, as defined in Section 265 of the Penal Code; (6) Sodomy, as defined in Section 286 of the Penal Code; (7) Oral copulation, as defined in Section 288a of the Penal Code; (8) Sexual penetration, as defined in Section 289 of the Penal Code; or (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code; or (f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions: (1) For punishment; (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given; or (3) For any purpose not authorized by the physician and surgeon (WIC Section 15610.83).

Serious bodily injury means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.87).

Neglect (a) means either of the following: (1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or (2) The negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise. (b) Neglect includes, but is not limited to, all of the following: (1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter; (2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment; (3) Failure to protect from health and safety hazards; (4) Failure to prevent malnutrition or dehydration; or (5) Failure of an elder or dependent adult to satisfy the needs specified in paragraphs (1) to (4), inclusive, for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health (WIC Section 15610.57).

**Financial abuse** of an elder or dependent adult occurs when a person or entity does any of the following: (1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; (2) Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; or (3) Takes, secretes, appropriates, obtains, or retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence, as defined in Section 15610.70 (WIC Section 15610.30(a)).
Abandonment means the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody (WIC Section 15610.05).

Isolation means any of the following: (1) Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls; (2) Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons; (3) False imprisonment, as defined in Section 236 of the Penal Code; or (4) Physical restraint of an elder or dependent adult, for the purpose of preventing the elder or dependent adult from meeting with visitors (WIC Section 15610.43).

Abduction means the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, of any elder or dependent adult who does not have the capacity to consent to the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, as well as the removal from this state or the restraint from returning to this state, of any conservatee without the consent of the conservator or the court (WIC Section 15610.06).

AS AN EMPLOYEE OR VOLUNTEER OF THIS FACILITY, YOU MUST COMPLY WITH THE DEPENDENT ADULT AND ELDER ABUSE REQUIREMENTS, AS STATED ABOVE. IF YOU DO NOT COMPLY, YOU MAY BE SUBJECT TO CRIMINAL PENALTY. IF YOU ARE A LONG-TERM CARE OMBUDSMAN, YOU MUST COMPLY WITH FEDERAL AND STATE LAWS, WHICH PROHIBIT YOU FROM DISCLOSING THE IDENTITIES OF LONG-TERM RESIDENTS AND COMPLAINANTS TO ANYONE UNLESS CONSENT TO DISCLOSE IS PROVIDED BY THE RESIDENT OR COMPLAINANT OR DISCLOSURE IS REQUIRED BY COURT ORDER (Title 42 United States Code Section 5058g(d)(2); WIC Section 9725).

I, ____________________________, have read and understand my responsibility to report known or suspected abuse of dependent adults or elders. I will comply with the reporting requirements.

SIGNATURE ____________________________ DATE ____________________________
SUPERVISOR EVALUATION

Please pay careful attention to the name of the supervisor. You are to rate only the course and supervisor represented in the evaluation, not the program in its entirety. The first two sections are regarding INDIVIDUAL supervision, while the last addresses GROUP.

The following survey is for MFT 694 with *supervisor* in *academic term/year*.

Your feedback is completely anonymous and will not be provided to the supervisor until after grades have been submitted at the end of the term. Chapman University is committed to ensuring equality and valuing diversity. Students and professors are reminded to show respect for all members of the Chapman community at all times. Your comments about the course and instruction are taken very seriously.

Q1 Please rate your *individual supervisor's* management of supervision:

<table>
<thead>
<tr>
<th>Strongly Agree (1)</th>
<th>Agree (2)</th>
<th>Neutral (3)</th>
<th>Disagree (4)</th>
<th>Strongly Disagree (5)</th>
<th>Not Applicable (6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clearly established and explained the supervision contract</td>
<td></td>
<td></td>
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<tr>
<td>2. Was clear in how I was to be evaluated</td>
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<tr>
<td>3. Began individual supervision on time</td>
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<tr>
<td>4. Was available for consultation in clinical emergencies</td>
<td></td>
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<tr>
<td>5. Observed my sessions and provided me with useful feedback</td>
<td></td>
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<tr>
<td>6. Allowed an open exchange of ideas and feelings</td>
<td></td>
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<tr>
<td>7. Created an environment in which I felt safe to receive feedback</td>
<td></td>
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<tr>
<td>8. Gave me positive feedback when I did something well</td>
<td></td>
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<tr>
<td>9. Helped me understand how my own feelings and experiences inform the treatment process</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10. Provided guidance in specific treatment protocols and interventions</td>
<td></td>
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</tr>
</tbody>
</table>
Q2 Please rate your **individual supervisor's** clinical competency:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree (1)</th>
<th>Agree (2)</th>
<th>Neutral (3)</th>
<th>Disagree (4)</th>
<th>Strongly Disagree (5)</th>
<th>Not Applicable (6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Established and maintained an effective working relationship with me</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Assisted me in developing clinical goals and objectives</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Assisted me in developing and refining assessment skills</td>
<td></td>
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<tr>
<td>4. Assisted me in conceptualizing cases and developing treatment plans based on specific theoretical models</td>
<td></td>
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<tr>
<td>5. Assisted me in the development and maintenance of clinical records</td>
<td></td>
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<tr>
<td>6. Shared information regarding ethical and legal aspects of professional practice</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7. Modeled and encouraged professional conduct</td>
<td></td>
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<tr>
<td>8. Demonstrated the ability to apply research to clinical practice</td>
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<tr>
<td>9. Provided feedback on my progress, strengths and weaknesses</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>10. Provided guidance in specific treatment protocols and interventions</td>
<td></td>
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</tr>
<tr>
<td>11. Demonstrated respect for cultural diversity in clinical cases</td>
<td></td>
<td></td>
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<tr>
<td>12. Overall, my supervisor was effective in his or her role as an individual supervisor</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Q3 Please rate your **group supervisor's** management of practicum course:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree (1)</th>
<th>Agree (4)</th>
<th>Neutral (5)</th>
<th>Disagree (6)</th>
<th>Strongly Disagree (7)</th>
<th>Not Applicable (8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clearly explained the course syllabus and was clear on how I was to be evaluated</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. Began group supervision on time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Allowed an open exchange of ideas and feelings within group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Created an environment in which I felt safe to give and receive feedback within group</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. Created an environment in which group members felt safe to give and receive feedback</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Gave positive feedback when someone in group did something well</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. Provided useful feedback during video case presentations that helped me grow as a therapist</td>
<td></td>
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</tr>
<tr>
<td>8. Provided useful feedback during live clinical observations that helped me grow as a therapist</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9. Overall, my supervisor was effective in his or her role as a group supervisor</td>
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</tr>
</tbody>
</table>
# Substances Use Survey

**Client Name:** ___________________________  **Today’s Date:** ___________

In order to provide you with the appropriate level of care, please complete this form (answer all questions):

1. Please list all chemicals you have used, and indicate how much you used (amount) and circle how often. Please write a “P” next to your primary drug of choice.

<table>
<thead>
<tr>
<th>AGE</th>
<th>CHEMICAL</th>
<th>COMMON NAMES</th>
<th>STARTED</th>
<th>LAST USE</th>
<th>AMOUNT/HOW OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ALCOHOL</td>
<td></td>
<td></td>
<td></td>
<td>Amount: Daily</td>
</tr>
<tr>
<td></td>
<td>AMPHETAMINES</td>
<td>Speed, Meth, Ice</td>
<td></td>
<td></td>
<td>Amount: Daily</td>
</tr>
<tr>
<td></td>
<td>CANNABIS</td>
<td>Marijuana</td>
<td></td>
<td></td>
<td>Amount: Daily</td>
</tr>
<tr>
<td></td>
<td>HALLUCINOGENS</td>
<td>LSD, mushrooms, Ecstasy</td>
<td></td>
<td></td>
<td>Amount: Daily</td>
</tr>
<tr>
<td></td>
<td>INHALANTS</td>
<td></td>
<td></td>
<td></td>
<td>Amount: Daily</td>
</tr>
<tr>
<td></td>
<td>OPIATES</td>
<td>Oxycodon, codeine, heroin, morphine, methadone</td>
<td>Daily</td>
<td></td>
<td>Amount: Daily</td>
</tr>
<tr>
<td></td>
<td>PCP</td>
<td></td>
<td></td>
<td></td>
<td>Amount: Daily</td>
</tr>
<tr>
<td></td>
<td>SEDATIVES/HYPNOTICS/</td>
<td></td>
<td></td>
<td></td>
<td>Amount: Daily</td>
</tr>
<tr>
<td></td>
<td>ANXIOLYTICS</td>
<td></td>
<td></td>
<td></td>
<td>Amount: Daily</td>
</tr>
<tr>
<td></td>
<td>COCAINE</td>
<td>Coke, Smack, Blow, Crack</td>
<td>Daily</td>
<td></td>
<td>Amount: Daily</td>
</tr>
</tbody>
</table>

**NOTE:** Please write a “P” next to your drug of choice.

2. Which of these have you had?

___ Blackouts
___ Overdoses
___ Bad reactions
___ Detoxification in a hospital
___ Withdrawal symptoms
___ Other problems: ___________________
5. How would you describe your use of alcohol/drugs:

<table>
<thead>
<tr>
<th>ALCOHOL:</th>
<th>DRUG USER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>____ Social drinker</td>
<td>____ Recreational drug user</td>
</tr>
<tr>
<td>____ Heavy drinker/heavy drug user</td>
<td>____ Have an addiction</td>
</tr>
<tr>
<td>____ Have alcoholism/drug addiction</td>
<td>____ Have a drug problem</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td>Other: ________________________</td>
</tr>
</tbody>
</table>

6. TREATMENT FOR SUBSTANCE USE:

<table>
<thead>
<tr>
<th>From/To</th>
<th>Agency/Provider Program</th>
<th>Voluntary</th>
<th>In Aftercare</th>
<th>Did you find it helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

TYPES OF PROGRAMS:

- AA/NA = 12-STEP
- OP = OUTPATIENT COUNSELING
- IT = INPATIENT
- TREATMENTID = INPATIENT DETOXIFICATION
- PROP 36 TREATMENT
- O = OTHER

7. FAMILY HISTORY: Please provide information about family members' use of alcohol/drugs:

<table>
<thead>
<tr>
<th>FAMILY MEMBER</th>
<th>ALCOHOL PROBLEM</th>
<th>DRUG PROBLEM</th>
<th>PLEASE SPECIFY DRUG (IF KNOWN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FATHER/STEPFATHER</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>MOTHER/STEPMOTHER</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>SIBLING(S)</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>PATERNAL GRANDPARENT</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>MATERNAL GRANDPARENT</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>OTHER (SPECIFY)</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>
FRANCES SMITH CENTER FOR INDIVIDUAL & FAMILY THERAPY
SUPERVISION CONTRACT

The purpose of this contract is to create and outline an agreed-upon context for the supervision experience between us. It will detail how, and under what conditions, clinical supervision will be provided. Please keep a copy of this contract for future reference.

Supervisor:
Name: ____________________________
Address: Chapman University/Frances Smith Center for Individual and Family Therapy
One University Dr., Orange, CA 92866
Telephone Number: Office: (949) 951-8369, ext. 2 Cell: ____________________________

Supervisee:
Name: ____________________________
Address: ____________________________
Telephone Number: Home: ( ) Cell: ( )

Outline of Logistics:
We have agreed to commit approximately ________ hours to some form of supervision contact, beginning the week of xx/xx/xx and continuing through the week of xx/xx/xx. Our regular time to meet for individual supervision will be every ______________ at ________ am/pm.

The format of supervision will include the following:

- Review of case notes
- Live supervision
- Audiotape
- Discussion
- Recording
- Other ____________________________

A supervisor’s signature is required for every client file discussed. The supervisee will provide updated and complete client files when meeting for supervision. All client cases must be discussed with the supervisor a minimum of once a month. Any directives from the supervisor to the trainee should be written in the supervisor’s notes. The supervisee will provide information and the supervisor will inquire about any client case in which dangerousness exists and such discussions must be documented in the client’s file. All clinic forms in a client’s file which must be reviewed and signed by your supervisor must be completed within five working days and submitted for signature by the Clinic Director. Forms are not legal until all signatures are obtained.

In Case of an Emergency:
A psychological emergency exists when, if someone doesn't get immediate help, serious psychological or physical consequences result. Examples of psychological emergencies include: an individual is actively suicidal or a danger to others; an individual is out of touch with reality (hallucinations, uncontrolable behavior, complete withdrawal); and severe drug or alcohol reactions. Brief psychiatric hospitalization can often help the person in an emergency. In any emergency where you, the client, or any other individual is in imminent danger, call 911 or the Police in the city in which the client is at the time and follow the agreed-upon procedures which follow.
In case of an emergency, we have discussed the following procedures:

In cases of imminent harm to self or others and client is not willing or able to go to nearest treatment facility or emergency room, call 9-1-1, then contact me to apprise me of the situation. In cases where you become aware of a client that is suicidal, homicidal, violent, or psychotic, but there appears to be no imminent risk, please notify me as soon as possible after becoming aware of this to review the status with me. In addition, please contact me immediately of any cases of potential child or dependent adult/elder abuse. If you are uncertain as to whether it is an emergency or not, you are encouraged to consult with me as needed.

Clarification of the Supervision Relationship:

Confidentiality: It is imperative that clients’ confidentiality be protected. No discussion of an identified client will be permitted outside of the actual supervision experience. General discussion of cases will only occur in counseling offices and not in hallways, restrooms, or outside the building. Confidentiality must be extended to the use of phone conversations with clients or outside consultants and take into consideration cases where individuals other than the client must be contacted where the English language is not spoken. Use of e-mail with clients is prohibited, as well as use of social media.

Expectations of trainee weekly supervision: Supervision is a class (MFT694); therefore, an attendance policy is in place. Trainees who miss group or individual supervision are expected to re-schedule during that week in order to count client hours during that week. **Trainees who miss three (3) or more group supervisions, individual supervision or combination of both will receive a No Pass/failing grade for the class.**

Management of weekly supervision: In case of supervisor’s inability to provide supervision in a given week (due to illness, vacation, etc.) it is agreed that 1) the supervisor will arrange for a substitute supervisor, 2) the trainee will not see clients during that week, or 3) the supervisor will not sign for hours of experience gained during that week.

Management of vacations and other time off from Clinic which affects client hours: It is understood that no trainee will take more than two consecutive weeks off during the regular semester or when clients are normally seen. All requests for vacation or time off for any reason must be in writing a minimum of two weeks in advance with a copy to the supervisor and to the Associate Clinic Director.

Dual supervision/additional consultation: In cases of more than one supervisor or outside consultation about a client occurs, it is incumbent upon the trainee to notify the supervisors/consultants and have agreement on how to discuss cases and handle conflicting directives.

Discussion re: scope of services and competence of trainee: The trainee and supervisor must discuss cases where questions of scope of practice for the MFT trainee may be questionable, or where the competence of the trainee in any given case may be lacking.

Discussion re: required consultation with supervisor: The trainee must consult and obtain approval of any change of service to clients, including frequency of sessions, length of sessions, change in modality, e.g. family to individual, additional counselors, intended use of collaborative data by third parties in session, and any decision involving bringing in outside consultants or practitioners to individual or group sessions. All psycho-educational groups must be approved with a complete outline of intended goals, teaching techniques, and handouts.

Trainee evaluation: A copy of the evaluation form has been reviewed with you. The supervisor will discuss with the trainee when the formal evaluation will take place. In addition, discussion about a trainee’s performance may occur between the current group and individual supervisor, as well as during supervision meetings with the Clinic Director. The purpose of such discussions is to assess whether additional support
and oversight is needed for the trainee to be successful, other issues as they relate to the trainee’s performance with a client, or to ascertain the appropriateness of the client for the Center.

**Discussion of personal relationships with clients:** The supervisor will clarify that personal relationships between the supervisee and clients will not be condoned. The supervisee should inform the supervisor of any fantasies that may occur between the client and supervisee, and a copy of the brochure *Therapy Never Includes Sex* is available.

**Ethical and legal guidelines:** It is agreed that all work done by the trainee and under supervision will adhere to the legal and ethical guidelines of the California Board of Behavioral Sciences, CAMFT, and AAMFT.

**Conflict in supervision:** It is the supervisee’s responsibility to address any discomfort that occurs in supervision with the supervisor directly. Quality supervision does not include placing the delivery of services before the trainee’s professional needs and it does not include providing psychotherapy to the trainee. Both the supervisor and supervisee should discuss conflict when it occurs, take responsibility for his/her role in the conflict, and agree to seek consultation in situations where an impasse is reached. In cases where resolution cannot occur, it is agreed that it will be handled by:

---

**Identification of Goals:**

| Trainee: __________________________ |

We have identified the following goals for our work together:

1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________
4. __________________________________________________________

---

Trainee’s Signature __________________________

Supervisor’s Signature __________________________

Dated: __________________________

Dated: __________________________

(Rev. 12/2018)
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SUPERVISOR SUMMARY FOR MFT TRAINEE EXPERIENCE
BASIC SKILLS EVALUATION DEVICE©

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<tr>
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<tr>
<td>Supervisor</td>
<td>Experience Level</td>
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### Conceptual Skills

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<th>Below Expectation</th>
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<th>Exceptional Skills</th>
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<td>3. Familiarity with Therapy Model</td>
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<td>4. Self as Therapist</td>
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### Perceptual Skills

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<td>2. Hypothesizing</td>
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<td>3. Integration of theory practice</td>
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<td>4. Interventions</td>
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<td>4. Professional Image</td>
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<tr>
<td>5. Professional Conduct</td>
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<td>2. Evaluation of Self</td>
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<td>Utilizes Theory in Practice</td>
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<td>Recognizes Strengths and Weakness of Theory</td>
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**Comments:**

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©Thorana S. Nelson, PhD

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Supervisor's Signature: __________________________

Supervisor's Printed Name: Susan Jester, M.A., LMFT

License Number: MFC 31869

Date: 01/23/19

My signature below indicates that I have read this evaluation. I am aware that I have the right to respond to it in writing and to have my response placed with this evaluation in my student file.

---

Signature of Trainee: __________________________

Trainee's Student ID No.: _____________________

Date: ____________________
SUSPECTED CHILD ABUSE REPORT
(Pursuant to Penal Code section 11166)

To Be Completed by Mandated Child Abuse Reporters
PLEASE PRINT OR TYPE

<table>
<thead>
<tr>
<th>CASE NAME:</th>
<th>CASE NUMBER:</th>
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A. REPORTING PARTY

<table>
<thead>
<tr>
<th>NAME OF MANDATED REPORTER</th>
<th>TITLE</th>
<th>MANDATED REPORTER CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>REPORTER’S BUSINESS/AGENCY NAME AND ADDRESS</td>
<td>Street</td>
<td>City</td>
</tr>
<tr>
<td>REPORTER’S TELEPHONE (DAYTIME)</td>
<td>SIGNATURE</td>
<td>TODAY’S DATE</td>
</tr>
</tbody>
</table>

B. REPORT NOTIFICATION

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<tr>
<th>AGENCY</th>
<th>ADDRESS</th>
<th>Street</th>
<th>City</th>
<th>Zip</th>
<th>DATE/TIME OF PHONE CALL</th>
</tr>
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<tbody>
<tr>
<td>OFFICIAL CONTACTED - NAME AND TITLE</td>
<td>TELEPHONE</td>
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C. VICTIM

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<tr>
<th>PHYSICALLY DISABLED?</th>
<th>DEVELOPMENTALLY DISABLED?</th>
<th>OTHER DISABILITY (SPECIFY)</th>
<th>PRIMARY LANGUAGE SPOKEN IN HOME</th>
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<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
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D. INVOLVED PARTIES

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<tr>
<th>VICTIMS (BIRTHDAYS)</th>
<th>NAME</th>
<th>BIRTHDATE</th>
<th>SEX</th>
<th>ETHNICITY</th>
<th>NAME</th>
<th>BIRTHDATE</th>
<th>SEX</th>
<th>ETHNICITY</th>
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<td>1. FATHER/MOTHER</td>
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<tr>
<th>VICTIMS (GUARDIANS)</th>
<th>NAME</th>
<th>BIRTHDATE</th>
<th>SEX</th>
<th>ETHNICITY</th>
<th>NAME</th>
<th>BIRTHDATE</th>
<th>SEX</th>
<th>ETHNICITY</th>
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E. INCIDENT INFORMATION

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<tr>
<th>SUSPECT’S NAME (LAST, FIRST, MIDDLE)</th>
<th>BIRTHDATE OR APPROX. AGE</th>
<th>SEX</th>
<th>ETHNICITY</th>
<th>SUSPECT</th>
<th>BIRTHDATE</th>
<th>SEX</th>
<th>ETHNICITY</th>
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OTHER RELEVANT INFORMATION

Narrative Description (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/earlier or past incidents involving the victim(s) or suspect)

If necessary, attach extra sheet(s) or other form(s) and check this box. If multiple victims, indicate number.

DATE/TIME OF INCIDENT | PLACE OF INCIDENT

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code section 11169 to submit to DOJ a Child Abuse or Severe Neglect Indexing Form BCIA 8583 if (1) an active investigation was conducted and (2) the incident was determined to be substantiated.
DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM BCIA 8672

All Penal Code (PC) references are located in Article 2.5 of the California PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: http://leginfo.legislature.ca.gov/faces/codes.xhtml (specify "Penal Code" and search for sections 11164-11174.3). A mandated reporter must complete and submit form BCIA 8572 even if some of the requested information is not known. (PC section 11167(a).

I. MANDATED CHILD ABUSE REPORTERS
Mandated child abuse reporters include all those individuals and entities listed in PC section 11165.7.

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")
Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC section 11165.9.)

III. REPORTING RESPONSIBILITIES
Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof within 36 hours of receiving the information concerning the incident. (PC section 11166(a).)

No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC section 11172(a).)

IV. INSTRUCTIONS (continued)
SECTION B – REPORT NOTIFICATION: Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.

SECTION C – VICTIM (One Report per Victim): Enter the victim's name, birthdate or approximate age, sex, ethnicity, address, telephone number, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes/no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes/no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes/no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.

SECTION D – INVOLVED PARTIES: Enter the requested information for Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).

SECTION E – INCIDENT INFORMATION: If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

V. DISTRIBUTION
Reporting Party: After completing form BCIA 8572, retain a copy for your records and submit copies to the designated agency.

Designated Agency: Within 36 hours of receipt of form BCIA 8572, the initial designated agency will send a copy of the completed form to the district attorney and any additional designated agencies in compliance with PC sections 11166(j) and 11166(k).

ETHNICITY CODES
1 Alaskan Native
2 American Indian
3 Asian Indian
4 Black
5 Cambodian
6 Caribbean
7 Central American
8 Chinese
9 Ethiopian
10 Filipino
11 Guamanian
12 Hawaiian
13 Hispanic
14 Hmong
15 Japanese
16 Korean
17 Laotian
18 Mexican
19 Other Asian
20 Other Pacific Islander
21 Polynesian
22 Polynesian
23 Samoan
24 South American
25 Vietnamese
26 White
27 White-Armenian
28 White-Central American
29 White-European
30 White-Middle Eastern
31 White-Romanian
TELEPHONE INTAKE – INDIVIDUAL

IF “NO” TO ALL (1-10), ASSIGN AS ROUTINE STATUS.

☐ YES ☐ NO 1. Is the client actively suicidal or may be a threat to others (has intent and plan)?
☐ YES ☐ NO 2. Is the client now having homicidal thoughts or dreams, or thoughts/dreams of hurting others?
☐ YES ☐ NO 3. Has the client been hospitalized for psychiatric reasons within the past 3 years?
☐ YES ☐ NO 4. Does the client currently have any psychotic symptoms (i.e., hallucinations, delusions, or disorganized thinking) that are not adequately managed through psychiatric care?
☐ YES ☐ NO 5. Does the client have a significant substance abuse problem that requires specific treatment?
☐ YES ☐ NO 6. Possible legal issues beyond scope of practice/competence (e.g., custody, disability evaluation, etc.)

IF “YES” TO ANY (1-6), THEN REFER OUT. Describe: ____________________________ (Rev. 2/22/10)

☐ YES ☐ NO 7. Does the client report any current suicidal ideation/history of attempts made > 1 year ago)?
☐ YES ☐ NO 8. Has the client ever been hospitalized for psychiatric reasons? If yes, _____ years ago.
☐ YES ☐ NO 10. Does the client report a level of substance use that requires further assessment?

IF “YES” TO ANY (7-10), CLIENT WILL HAVE AN EXTENDED ASSESSMENT. He/she may be eligible for services in our Center, and will meet with a trainee and/or supervisor for assessment, after which they will begin treatment or receive referrals. The Center Director/Clinic Director must sign off on the disposition decisions of all extended assessments.

*****************************************************************************************************

CLIENT NO.: ___________________________________________ REVIEWED BY
CLINIC DIRECTOR: ________________________________

ASSIGNED TO: ________________________________ ASSIGNMENT DATE: ________________

DISPOSITION: ☐ ROUTINE ☐ EXTENDED ASSESSMENT ☐ REFERRED OUT

TODAY’S DATE: ________________ TIME: ________________ CALL TAKEN BY: ________________________________

CLIENT NAME: ________________________________ GENDER: __________ AGE: __________ DATE OF BIRTH: ________________

ADDRESS WHERE YOU LIVE: ________________________________ PREFERRED ADDRESS FOR CORRESPONDENCE:
OR LETTERS: ____________________________________________

Street Apt/Unit # Street Apt/Unit #

City State Zip City State Zip

WHAT NUMBER SHOULD YOUR THERAPIST CALL TO REACH YOU: (____) ________________
☐ Cell ☐ Home ☐ Work

IS IT OKAY TO LEAVE A MESSAGE ON THIS NUMBER? ☐ YES ☐ NO

WHAT IS YOUR CURRENT LIVING SITUATION:
☐ SINGLE, LIVE ALONE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED
☐ SINGLE LIVE WITH FAMILY ☐ SINGLE LIVE WITH PARTNER ☐ SINGLE LIVE WITH ROOMMATE

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<table>
<thead>
<tr>
<th>WHO REFERRED YOU TO THE FRANCES SMITH CENTER:</th>
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</thead>
<tbody>
<tr>
<td>□ I’VE BEEN A CLIENT HERE BEFORE</td>
</tr>
<tr>
<td>□ FRIEND WHO IS A CENTER CLIENT</td>
</tr>
<tr>
<td>□ FAMILY</td>
</tr>
<tr>
<td>□ CHAPMAN STUDENT PSYCHOLOGICAL COUNSELING</td>
</tr>
<tr>
<td>□ OTHER: ______________________</td>
</tr>
<tr>
<td>□ O.C. MENTAL HEALTH ______________________</td>
</tr>
<tr>
<td>□ SCHOOL: ______________________</td>
</tr>
<tr>
<td>□ WEB/ON-LINE</td>
</tr>
<tr>
<td>□ COURT/PROBATION OFFICER (SEE NEXT SEC.)</td>
</tr>
<tr>
<td>□ SOCIAL SERVICES (SEE NEXT SECTION)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOTE: SKIP THIS SECTION IF THE CLIENT WAS NOT REFERRED BY THE COURT/PROBATION OFFICER/SOCIAL SERVICES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF YOU WERE REFERRED BY THE COURT/PROBATION OFFICER, OR SOCIAL SERVICES, WHAT ARE YOU BEING REFERRED FOR? FOR EXAMPLE: INDIVIDUAL THERAPY, ANGER MANAGEMENT, SUBSTANCE ABUSE, DOMESTIC VIOLENCE, ETC.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHAT EVENT(S) HAPPENED THAT RESULTED IN YOUR REFERRAL? PLEASE BE AS SPECIFIC AS POSSIBLE TO INSURE THAT WE CAN PROVIDE YOU WITH THE APPROPRIATE SERVICES:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Have you been seen at the Frances Smith Center in the past? □ YES □ NO</td>
</tr>
<tr>
<td>If yes, under what name and approximate date(s): ____________________________</td>
</tr>
<tr>
<td>Why did you end therapy? (e.g., met treatment goals, therapist graduated, moved away, didn’t like therapist, etc.)</td>
</tr>
<tr>
<td>Was therapy helpful to you? □ YES □ NO</td>
</tr>
<tr>
<td>If it was not helpful, why not? ______________________________________________</td>
</tr>
</tbody>
</table>

| THE FRANCES SMITH CENTER REQUIRES THERAPY SESSIONS TO OCCUR ON A WEEKLY BASIS. |
| ARE YOU WILLING TO COMMIT TO WEEKLY SESSIONS IF ASSIGNED? □ YES □ NO |

| HAVE YOU BEEN IN THERAPY ANYWHERE ELSE IN THE PAST? □ YES □ NO |
| If yes, what is the name of the most recent therapist/clinic? __________________________ |
| Located in what city/state? __________________________________________________ |
| What is the reason you sought therapy at that time? ______________________________ |
|Was the therapy helpful to you? □ YES □ NO |
|If it was not helpful, why not? ______________________________________________ |
HAVE YOU BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS? ☐ YES ☐ NO
IF YES, HOW MANY TIMES: __________________________

<table>
<thead>
<tr>
<th>Name of Hospital</th>
<th>City and State</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TELL ME BRIEFLY WHAT HAPPENED THAT RESULTED IN YOUR HOSPITALIZATION? ________________________________________

WAS THE HOSPITALIZATION: ☐ VOLUNTARY ☐ INVOLUNTARY
☐ SUICIDE ATTEMPT ☐ THREAT OF HARM TO OTHERS
☐ OTHER: __________________________

WHAT SYMPTOMS WERE YOU HAVING AT THE TIME YOU WERE HOSPITALIZED? ________________________________________

WERE YOU GIVEN A DIAGNOSIS? ________________________________________

WERE YOU PUT ON MEDICATION(S)? ☐ YES ☐ NO
IF YES, LIST: ________________________________________

ARE YOU CURRENTLY TAKING ANY PSYCHIATRIC MEDICATIONS? ☐ YES ☐ NO
IF YES, WHO PRESCRIBED THE MEDICATION? ☐ M.D./GENERAL PRACTITIONER ☐ PSYCHIATRIST
NAME: __________________________ CITY: __________________________

MEDICATION/DOSAGE: ________________________________________
WHAT ARE YOUR SYMPTOMS? ________________________________________

HAVE YOU TAKEN PSYCHIATRIC MEDICATIONS IN THE PAST? ☐ YES ☐ NO
IF YES: NAME OF MEDICATION(S): __________________________
WHY WERE YOU PRESCRIBED THE MEDICATION(S) – WHAT WERE YOUR SYMPTOMS? __________________________

WHY DID YOU STOP TAKING THE MEDICATION(S)?  ☐ Side Effects ☐ Family interference ☐ Loss of insurance
☐ Financial – Couldn’t afford it ☐ Transportation ☐ Diagnosis
☐ Religious or other beliefs ☐ Doesn’t like taking meds ☐ Other: __________________________
HOW MUCH ALCOHOL, IF ANY, DO YOU CURRENTLY DRINK:  
☐ NONE  
☐ I HAVE APPROXIMATELY _ DRINKS PER: ☐ DAY ☐ WEEK ☐ WEEKEND ☐ MONTH ☐ YEAR

HAVE YOU HAD A PROBLEM WITH ALCOHOL IN THE PAST?  ☐ YES ☐ NO  
IF YES, HOW LONG AGO:  ______________________________

ARE YOU NOW SOBER?  ☐ YES ☐ NO

HOW DID YOU DEAL WITH YOUR DRINKING PROBLEM?  
☐ JUST STOPPED DRINKING  ☐ WENT TO A TREATMENT PROGRAM  
☐ WENT TO AA  ☐ WENT TO A THERAPIST

DO YOU USE ANY “STREET DRUGS” (ILLEGAL) AT THIS TIME?  ☐ YES ☐ NO  
IF YES, WHAT ARE THEY?  
☐ DRUG: ________________________________ ☐ DAILY ☐ WEEKLY ☐ WEEKEND ☐ MONTH  
DRUG: ________________________________ ☐ DAILY ☐ WEEKLY ☐ WEEKEND ☐ MONTH

IF CLIENT REPORTS USING MARIJUANA:  
DO YOU HAVE A MEDICAL MARIJUANA CARD?  ☐ YES ☐ NO  
IF YES, PRESCRIBED BY: ________________________________

WHAT IS THE CONDITION FOR WHICH MARIJUANA HAS BEEN PRESCRIBED?  
__________________________________________

HAVE YOU HAD A DRUG PROBLEM IN THE PAST?  ☐ YES ☐ NO  
IF YES, HOW LONG AGO:  ________________________________  
☐ AMPHETAMINES (SPEED, METH, ICE)  ☐ INHALANTS  
☐ CANNABIS (MARIJUANA)  ☐ OPIATES (HEROIN, MORPHINE, OXYCODONE, VICODIN)  
☐ HALLUCINOGENS (LSD, MUSHROOMS, ECSTASY)  ☐ SEDATIVES/HYPNOTICS  
☐ OTHER: ________________________________

HAVE YOU SOUGHT TREATMENT FOR SUBSTANCE ABUSE IN THE PAST?  ☐ YES ☐ NO  
IF YES: NAME OF PROVIDER: ________________________________  
☐ INPATIENT ☐ OUTPATIENT  
CITY/STATE: ________________________________ APPROX. DATE: ________________
WHAT IS THE REASON YOU ARE SEEKING COUNSELING AT THIS TIME?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

WHEN DID THIS PROBLEM FIRST OCCUR: ____________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

WHAT HAVE YOU DONE TO TRY TO HELP YOURSELF REGARDING THIS PROBLEM? __________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

☐ YES ☐ NO HAVE YOU HAD PROBLEMS HEARING THINGS THAT OTHER PEOPLE DO NOT HEAR? IF YES,

Describe: _______________________________________________________________________

☐ YES ☐ NO HAVE YOUR THOUGHTS BEEN FEELING STRANGE OR OUT OF CONTROL? IF YES, DESCRIBE:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

☐ YES ☐ NO 1. ARE YOU HAVING SUICIDAL THOUGHTS AT THIS TIME?

☐ YES ☐ NO 2. IF “YES,” DO YOU HAVE A PLAN? WHAT IS IT: ____________________________

☐ YES ☐ NO 3. HAVE YOU MADE ANY SUICIDE ATTEMPTS IN THE PAST? IF “YES”:

<table>
<thead>
<tr>
<th>Approx. Date</th>
<th>Method</th>
<th>Did you tell anyone at the time?</th>
<th>Hospitalized as a result?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. _________</td>
<td>_______________</td>
<td>☐ Yes ☐ No ☐ Yes ☐ No</td>
<td>☐ Yes ☐ No ☐ Yes ☐ No</td>
</tr>
<tr>
<td>2. _________</td>
<td>_______________</td>
<td>☐ Yes ☐ No ☐ Yes ☐ No</td>
<td>☐ Yes ☐ No ☐ Yes ☐ No</td>
</tr>
</tbody>
</table>
4. ARE YOU HAVING ANY THOUGHTS OR DREAMS OF HURTING SOMEONE AT THIS TIME?

IF YES, PLEASE DESCRIBE: __________________________________________________________
___________________________________________________________

(NOTE: IF THE CLIENT ANSWERS “YES” TO QUESTION 2 OR 4 ABOVE, ESTABLISH A VERBAL NO-HARM CONTRACT. IF CALLER WILL NOT DO THIS, CONTACT THE CLINIC DIRECTOR IMMEDIATELY.)

WHEN ARE YOU AVAILABLE FOR COUNSELING? PLEASE LET US KNOW GENERAL DAYS AND TIMES THAT WOULD WORK ON A WEEKLY BASIS. MORE AVAILABILITY WILL HELP WHEN ASSIGNING A COUNSELOR TO YOU.

MONDAYS: _______ TUESDAYS: _______ WEDNESDAYS: _______

THURSDAYS: _______ FRIDAYS: _______ SATURDAYS: _______

THE FRANCES SMITH CENTER FOR INDIVIDUAL & FAMILY THERAPY IS A TRAINING CLINIC LOCATED ON THE CAMPUS OF CHAPMAN UNIVERSITY. ALL COUNSELORS ARE GRADUATE STUDENTS IN THE LAST YEAR OF THE MARRIAGE AND FAMILY THERAPY PROGRAM AND ARE SUPERVISED BY LICENSED THERAPISTS. FEES ARE ASSESSED ON A SLIDING SCALE, BASED UPON MONTHLY GROSS INCOME.

IN ORDER TO QUOTE YOUR FEE, I NEED TO KNOW YOUR MONTHLY GROSS INCOME: $ _________

☐ EMPLOYMENT ☐ FULL-TIME ☐ PART-TIME ☐ PER DIEM/CONTRACT
☐ UNEMPLOYMENT ☐ CHILD SUPPORT/ALIMONY ☐ DISABILITY ☐ SSI/SOCAL SECURITY
☐ WORKERS COMP ☐ AFDC/WELFARE ☐ SAVINGS ☐ OTHER: ____________________________
☐ NONE – IF CLIENT IS AN ADULT AND LIVING ALONE OR WITH ROOMMATES, ASK WHO IS PAYING RENT AND GET AMOUNT OF MONTHLY SUPPORT AND WHO IS PROVIDING IT: ____________________________

BASED ON YOUR INCOME, YOUR SESSION FEE IS: $ _________

NOTE: IS CLIENT A CHAPMAN STUDENT? ☐ YES ☐ NO

ASK IF THEY ARE AN: ☐ UNDERGRADUATE ☐ GRADUATE

IF CLIENT IS AN UNDERGRADUATE, ASK IF HE/SHE WAS REFERRED BY THE STUDENT ☐ YES ☐ NO PSYCHOLOGICAL COUNSELING CENTER (SPCS). IF NO, REFER STUDENT BACK TO SPCS FOR FREE COUNSELING SERVICES.

IF CLIENT IS A GRADUATE STUDENT, HAS HE/SHE PAID THE HEALTH & COUNSELING FEE? ☐ YES ☐ NO IF YES, REFER STUDENT BACK TO SPCS FOR FREE COUNSELING SERVICES.

IF CLIENT HAS BEEN REFERRED BY SPCS OR IS A GRADUATE STUDENT WHO HAS NOT PAID THE HEALTH & COUNSELING FEE, THEIR SESSION FEE IS: $15.00
□ YES □ NO Although the center cannot accept insurance, it is helpful to know if you have insurance in the event any referrals are made:

If yes, what kind:

□ Group thru employer □ Medi-Cal / Cal Optima / Healthy Families
□ Private health insurance □ Medicare
□ Kaiser □ School insurance
□ MSI □ Other: __________________________

Tell the caller that the intake will be given to the clinic director who will review it. He/she will receive a call from the assigned therapist or the clinic director within 1-2 days. Does the person have any other questions? If you can’t answer them, write them down for the clinic director to follow-up.
COMPONENTS OF COUPLE NEGOTIATED
TIME-OUT – CLIENT GUIDE

Step 1: Awareness
What are the physical, behavioral, and emotional responses you experience as you begin to get angry?

Step 2: Staying Within the Safety Zone
What are some techniques you can use to stay within the safety zone.

Step 3: Signaling
What is your mutually agreed upon signal for a time-out?

Step 4: Acknowledging
If one of you wants to continue the argument, what can you do to resist the urge to continue the discussion?

(Over)
Step 5: Disengaging

1. Where will you go when you call a time-out? Where will you go when your partner calls a time-out?

2. If you have children, who will watch the children when one of you takes a time-out?

Step 6: Cooling Off

1. What activities will be most effective for each of you to use to calm yourself, and prepare to return to your partner?

Step 7: Returning

1. How can you agree upon a future course of action when you return from the fight?

What a time-out is not:

1. *Time-Out is not a way to get out of an important discussion just because you do not want to have it.*
2. *Time-Out is not a way to control your partner*

(Time Out Instructions)
COMPONENTS OF COUPLE NEGOTIATED TIME-OUT - THERAPIST GUIDE

Step 1: Awareness
Descriptor: Learning to recognize internal cues that anger is escalating.
Additional Considerations: (a) Partners may have different comfort levels with intense emotion: one may be ready for a time-out before the other has reached his/her warning level, (b) Both partners take ownership for their responses and agree to act in a way that maintains safety.

1. What are the physical, behavioral, and emotional responses you experience as you begin to get angry?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Step 2: Staying Within the Safety Zone
Descriptor: Deciding that anger may escalate past the safety zone and a time-out is needed.
Additional considerations: Either partner may initiate a time-out. The victim may feel more in control knowing that she can initiate should her own or her partner’s anger escalate.

1. What are some techniques you can use to stay within the safety zone.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Step 3: Signaling
Descriptor: The initiator signals a time-out using a hand gesture, such as a “T” symbol saying in a calm voice “I am going to take a time-out”.
Additional Considerations: Partners negotiate what the signal will be and select one that is clear and not threatening.

1. What is your mutually agreed upon signal for a time-out?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Step 4: Acknowledging
Descriptor: The other partner acknowledges the time out.
Additional considerations: Partners plan ways to resist the urge to continue the argument.

1. If one of you wants to continue the argument, what can you do to resist the urge to continue the discussion?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

(Over)
Step 5: Disengaging
Descriptor: Partners go to separate locations.
Additional considerations: Partners negotiate a specified location, plans for caring for children, and amount of time needed for the time out.

1. Where will you go when you call a time-out? Where will you go when your partner calls a time-out?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

2. If you have children, who will watch the children when one of you takes a time-out?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Step 6: Cooling Off
Descriptor: Partner who initiates time-out spends time doing calm activities.
Additional considerations: Both partners may need to cool off and may need help in finding ways to calm themselves.

1. What activities will be most effective for each of you to use to calm yourself, and prepare to return to your partner?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Step 7: Returning
Descriptor: Partners reconnect and continue discussion if calm.
Additional considerations: Partners know they have the option of taking another time-out, tabling the discussion until their next session or dropping the discussion altogether.

1. How can you agree upon a future course of action when you return from the fight?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What a time-out is not:

1. Time-Out is not a way to get out of an important discussion just because you do not want to have it.
2. Time-Out is not a way to control your partner
## INTAKE SUMMARY □ TREATMENT SUMMARY □ (check one)

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>DOB:</th>
<th>Sex:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Session Date:</td>
<td>Final Session Date:</td>
<td></td>
</tr>
<tr>
<td>Treatment Modality: Individual</td>
<td>Total No. of</td>
<td></td>
</tr>
<tr>
<td>MFT Trainee:</td>
<td>Client No.:</td>
<td></td>
</tr>
<tr>
<td>Ethnic Identification:</td>
<td>Transferred to:</td>
<td></td>
</tr>
</tbody>
</table>

- [ ] Alaskan Native
- [ ] American Indian
- [ ] Asian Indian
- [ ] Black/African-American
- [ ] Cambodian
- [ ] Caribbean
- [ ] Central American
- [ ] Chinese
- [ ] Ethiopian
- [ ] Filipino
- [ ] Guamanian
- [ ] Hawaiian
- [ ] Hispanic
- [ ] Hmong
- [ ] Japanese
- [ ] Korean
- [ ] Laotian
- [ ] Mexican
- [ ] Multiracial
- [ ] Other Asian
- [ ] Other Pacific Islander
- [ ] Polynesian
- [ ] Samoan
- [ ] South American
- [ ] Vietnamese
- [ ] White-Armenian
- [ ] White-Central American
- [ ] White-European
- [ ] White-Middle Eastern
- [ ] White-Romanian

### PRESENTING COMPLAINT(S) (include descriptions of the problem, when it first occurred, and what the client has attempted to resolve the problem):


### PSYCHOSOCIAL HISTORY

<table>
<thead>
<tr>
<th>Family of Origin History: (quality of parental and sibling relationships, number of siblings, birth order, significant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital and Relationship History: (length of marriage, number and ages of children, divorces)</td>
</tr>
</tbody>
</table>
PSYCHOSOCIAL HISTORY (cont.)

<table>
<thead>
<tr>
<th>Section</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental History</td>
<td>(early development, life transitions including deaths, moves, crises)</td>
</tr>
<tr>
<td>Work/Employment History</td>
<td>(current and previous jobs, reasons for leaving employment)</td>
</tr>
<tr>
<td>Educational History</td>
<td>(Highest level of education achieved, behavioral problems, achievements)</td>
</tr>
<tr>
<td>Cultural History</td>
<td>(Cultural identity, length of time in US, languages spoken, cultural)</td>
</tr>
<tr>
<td>Military History</td>
<td>(include any military service or service of significant others)</td>
</tr>
<tr>
<td>Other</td>
<td>(include information not directly assessed for above, but which may be important for)</td>
</tr>
</tbody>
</table>
MENTAL HEALTH HISTORY

Current psychotropic medications:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(List meds/dosages):</td>
<td></td>
</tr>
</tbody>
</table>

Prescribed by:

<table>
<thead>
<tr>
<th></th>
<th>Psychiatrist: Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physician: Name:</td>
<td></td>
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</tbody>
</table>

Previous therapy:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>None reported</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frances Smith Center for Individual and Family Therapy (see previous treatment summary)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approximate date(s), focus of therapy, and satisfaction:</td>
<td></td>
</tr>
</tbody>
</table>

Psychiatric Hospitalization(s):

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>None reported</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes: Include approx. dates, voluntary or involuntary, and reason</td>
<td></td>
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</tbody>
</table>

History of Suicidal Ideation/Attempt(s):

<p>| | | |</p>
<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>None reported</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ideation only (state)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suicide Attempts: (state when/means)</td>
<td></td>
</tr>
</tbody>
</table>

History of Substance abuse/dependence

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>None reported</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abuse only: (Specify types and duration)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dependence: (Specify types and duration)</td>
<td></td>
</tr>
</tbody>
</table>

Family History of Mental Illness:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>None reported</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes: (identify who and illness, if known)</td>
<td></td>
</tr>
</tbody>
</table>

Criminal / Legal History:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>None reported</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes: (examples may include DUI, custody arrangements, domestic violence, etc.)</td>
<td></td>
</tr>
</tbody>
</table>
### ASSESSMENT / TESTING

- No psychological testing was done.

### Testing was done as follows:

<table>
<thead>
<tr>
<th>Test</th>
<th>Date:</th>
<th>Pre-Tx</th>
<th>Mid-Tx</th>
<th>Post-Tx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Questionnaire</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beck Anxiety Inventory</td>
<td>Date:</td>
<td>Score:</td>
<td>Minimal</td>
<td>Mild</td>
</tr>
<tr>
<td>Beck Depression Inventory-II</td>
<td>Date:</td>
<td>Score:</td>
<td>Minimal</td>
<td>Mild</td>
</tr>
<tr>
<td>Beck Hopelessness Scale</td>
<td>Date:</td>
<td>Score:</td>
<td>Minimal</td>
<td>Mild</td>
</tr>
<tr>
<td>Child Behavioral Checklist Youth Self Report</td>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting Stress Index</td>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyadic Adjustment Scale</td>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflict Tactics Scale</td>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood Disorder Questionnaire</td>
<td>Date:</td>
<td>No. of Symptoms: *</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Marital Satisfaction Inventory-Rev (MSI-R)</td>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>Date:</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Summary of Test Results:

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Date</th>
<th>Change in Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score (Total &gt;63 = Dysfunctional)</td>
<td></td>
<td></td>
<td>Improved (Decrease 14+ pts)</td>
</tr>
<tr>
<td>Symptom Distress (SD &gt; 36 = Dysfunctional)</td>
<td></td>
<td></td>
<td>Improved (Decrease 10+ pts)</td>
</tr>
<tr>
<td>Interpersonal Relationship (IR &gt; 15 = Dysfunctional)</td>
<td></td>
<td></td>
<td>Improved (Decrease 8+ pts)</td>
</tr>
<tr>
<td>Social Role (SR &gt; 12 = Dysfunctional)</td>
<td></td>
<td></td>
<td>Improved (Decrease 7+ pts)</td>
</tr>
<tr>
<td>Critical Items:</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Suicide (#8)</td>
<td></td>
<td></td>
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<tr>
<td>Substance Abuse (#11,26,32)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Violence at work (#44)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>0=Never 3=Frequently 1=Rarely 4=Almost Always 2=Sometimes</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Treatment Considerations from Test Results:

DIAGNOSIS

<table>
<thead>
<tr>
<th>CODE</th>
<th>DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Diagnostic Summary (include specific symptoms, course, intensity, and impacts to life domains):

SYSTEMIC CONCEPTUALIZATION/TREATMENT PLAN:

Systemic Case Conceptualization (summarize your understanding of the most relevant factors explaining the client’s complaint(s):
## TREATMENT PLAN:

A) List between 1 and 3 specific and measurable goals, B) List a general treatment approach (i.e., Bowenian, CBT, ACT, IPT, EFT, TBCT, ICBT), c) List primary techniques you will use to accomplish treatment goals (i.e., genogram, communication skills, mindfulness, desensitization, tracking negative cycles, behavior exchange, empathic joining)

<table>
<thead>
<tr>
<th>General Approach:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 1:</td>
<td></td>
</tr>
<tr>
<td>Goal 2:</td>
<td></td>
</tr>
<tr>
<td>Goal 3:</td>
<td></td>
</tr>
<tr>
<td>Technique:</td>
<td></td>
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<tr>
<td>Technique:</td>
<td></td>
</tr>
<tr>
<td>Technique:</td>
<td></td>
</tr>
</tbody>
</table>

## CLIENT CENTERED ADVOCACY / REFERRALS:

- [ ] No referrals made
- [ ] Psychiatric evaluation
- [ ] Medical evaluation
- [ ] Substance abuse
- [ ] Other: (specify)
- [ ] Support group:
- [ ] Psychoeducational
- [ ] Legal:
- [ ] Psychological testing
REASON FOR TERMINATION (complete information below for terminations only):

<table>
<thead>
<tr>
<th>Reason for Termination</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown. Client did not show up to session or to letter mailed on:</td>
<td></td>
</tr>
<tr>
<td>Client terminated therapy by telephone.</td>
<td></td>
</tr>
<tr>
<td>Client met treatment goals and therapy was discontinued by mutual agreement</td>
<td></td>
</tr>
<tr>
<td>Therapist completed practicum and client requested to be transferred to another therapist to continue therapy.</td>
<td>Transferred to:</td>
</tr>
<tr>
<td>Other:</td>
<td>Specify:</td>
</tr>
</tbody>
</table>

PROGRESS OF TREATMENT AND RECOMMENDATIONS (including significant continuing problems or conditions):

<table>
<thead>
<tr>
<th>Progress of Treatment</th>
<th>Specify:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client participated in therapy and met treatment goals.</td>
<td></td>
</tr>
<tr>
<td>Limited progress was made.</td>
<td></td>
</tr>
<tr>
<td>Client was referred out for other services as a condition of therapy:</td>
<td>Specify:</td>
</tr>
<tr>
<td>Client was referred out for services and not appropriate for this Clinic.</td>
<td>Specify:</td>
</tr>
<tr>
<td>Other:</td>
<td>Specify:</td>
</tr>
</tbody>
</table>

Date:       Signature:  
*, MFT Trainee

Date:       Signature:  
* LMFT, Clinical Supervisor

Date:       Signature:  
Susan Jester, M.A., LMFT, Clinic Director
VACATION NOTIFICATION FORM

Trainee: ____________________________ Date: _______________________

I will be out of the Center for the following period:

Departure date: ____________________ Return date: _______________
(NOTE: This is the day you will be picking up your messages, etc.)

____ I will be picking up my own messages, so I have not designated an “on-call therapist.”

I have completed the following:

___ I have notified the Dept. Assistant (to highlight rooms).
___ I have obtained my Supervisor(s) signatures.
___ I have given this form to the Clinic Director.

OR

____ The “on-call therapist” will be covering my messages and any emergencies:

The “on-call therapist” is: ______________________________

I have completed the following:

___ I have advised my clients of the on-call therapist’s name and extension.
___ I have contacted the answering service and given them this information.
___ I have changed my voice mail recording to include this information.
___ I have notified the Dept. Assistant (to highlight rooms).
___ I have obtained my Supervisor(s) signatures.
___ I have given this form to the Clinic Director.

Dated: _______________ ______________________________
Signature of Trainee

Dated: _______________ ______________________________
Signature of Group Supervisor

Dated: _______________ ______________________________
Signature of Individual Supervisor

Dated: _______________ ______________________________
Signature of Director/Clinic Director
### MARRIAGE AND FAMILY THERAPIST TRAINEE / ASSOCIATE WEEKLY
#### SUMMARY OF EXPERIENCE HOURS

**OPTION 1 – NEW STREAMLINED METHOD**

<table>
<thead>
<tr>
<th>Name of Trainee/Associate:</th>
<th>Last</th>
<th>First</th>
<th>Mid dl e</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor Name</td>
<td>Date enrolled in graduate degree program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Work Setting (use a separate log for each)</td>
<td>Address of Work Setting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Indicate your status when the hours below are logged:  
- [ ] Trainee  
- [ ] Post-Degree / Associate Application Pending - BBS File No (if known): ________________  
- [ ] Registered Associate - AMFT Number: ________________

<table>
<thead>
<tr>
<th>YEAR__________</th>
<th>WEEK OF:</th>
<th>Total Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Direct Counseling with Individuals, Groups, Couples or Families</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1. Diagnosis and Treatment of Couples, Families, Children**</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. Non-Clinical Experience</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B1. Supervision, Individual or Triadic**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B2. Supervision, Group**</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C. Total Hours Per Week</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(A + B = C) (Maximum 40 hours / week)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Supervisor Signature

---

* Includes telehealth counseling.

** Line A1 is a sub-category of “A” and Lines B1 and B2 are subcategories of “B.” When totaling weekly hours do NOT include the subcategories - use the formula found in box “C.”

*** Non-Clinical Experience includes: Supervision, psychological testing, writing clinical reports, writing progress or process notes, client-centered advocacy, and workshops, seminars, training sessions or conferences.