Intake Form Analysis

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CNS 736: Appraisal Procedures for Counselors

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Assessment Interview Information

Assessment:

Name:

Other Members of Household:

Presenting Problem:

History of Presenting Problem:

Reason for Seeking Treatment:

Presentation/Observations:

Alert and Oriented, Mental Status, Affect, Mood, Physical, Appearance/Clothing

Sleep:

Appetite:

Medical/Mental Health/Substance Use History:

Social & Developmental History:

Family History:

Risk Factors:

Assessment Summary:

Treatment Plan

Client Strengths:

Treatment Goals:

Treatment Objectives:

Intervention Strategies:

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Effective

- **Protection from discrimination.** The information requested in our intake packet consists of information required by insurance companies and our state and federal governments. We do not ask many questions about a person's protected class or demographic information beyond their date of birth or age and any pertinent insurance information. This tactic is beneficial to ensure that we keep any internal or unconscious bias to a minimum when choosing our caseload.
- **It increases the client's understanding.** The information we give clients in the intake packet helps them understand the legal side of therapy. By including the client's rights and the HIPAA privacy information, the client is made aware of their rights as clients. The remaining information lets the client understand what is to expect during therapy, including any limitations to confidentiality and care.
- **Coordination of care.** By requiring an immediate ROI for the client's primary care physician, our forms make it much easier to complete care coordination.
- **Information Gathering.** With few exceptions, I love how our intake assessment is designed and its questions. It makes sure that we get a wide array of information and cover a lot of aspects of a client's life. It reminds us to pay attention to observable information like mental state, affect, and mood, rather than focusing solely on the client's self-report. It makes sure that we look at medications and medical history, family history, developmental and social history, and substance use history, including physical and mental illness. In short, it reminds us that anything can trigger cognitive, emotional, or behavioral concerns, so we need to look under every rock to find every possible cause.
- **Therapy from the onset.** Our intake assessment has strengths-based techniques built into the interview. The client is requested to name four strengths they feel they have (in the case of a minor, the client's guardian can help). This technique is fundamental to help many cases because it has the client look inside themselves to find good things, rather than only focusing on the bad.
- **We include the client in their treatment planning.** At the end of each assessment, as we discuss the client's strengths, we also have the client set their own goals for therapy or envision what they will look like when treatment is over. This inclusion helps them gain a sense of control over their treatment that may eventually extend into their own lives.
- **It is standardized.** By asking the same types of questions with each client and having them all sign the same indiscriminate forms, we protect ourselves from a discrimination claim.
- **Counselor-in-training consent!** Because my site prides itself on being a training facility, the basic consent form explicitly mentions the process of working with an unlicensed therapist. This brings attention to how the process works and allows the client to give consent to work with a student specifically.
- **Household information.** It may seem silly, but this question makes my life so much easier when asking this question during the assessment interview. I do not have to worry so much about making sure that I spell names correctly, as they will likely be on this form.
- **Cancellation and No-Show policies upfront.** Our waitlist is constantly full and closed, so having this be in the packet is extremely helpful when contacting a client based on their cancellation or no-show history.

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Ineffective

- **Observational Information.** As much as I love that our assessments have a part that discusses this information explicitly, I feel like having them on a checklist (as ours is) makes it way too easy to click "within normal limits" every time without really thinking about it. And honestly, what is considered "normal" anyway? Is it what is normal to the client or what is typical to society or the person's culture? They are extremely subjective questions that, while important, are not entirely necessary to fill out with every client. I think removing the checkboxes would be beneficial and have text boxes instead, so we have to think about it when writing.
- **Why they are seeking therapy now?** This question drives me up a wall. It is ineffective, as the client has likely answered it while discussing their symptoms and giving me some history about the problem. Removing it would be ideal.
- **Risk factors are an underutilized section.** As it stands, the only time we really put anything into this category is if the client states that they have some SI or HI. Then we just report that we completed a safety plan with them. We could use it for so much more, such as actually analyzing a client's risk factors and listing them so that we can keep an eye on those factors throughout the course of treatment.
- **The Cancellation and No-Show policy is incomplete.** I feel like this form needs to be updated to include our discharge based on attendance in-house policy. If we were to be even more upfront about our policy, I think we would have fewer people not show up or at least be more diligent about contacting us before their appointment.
- **Intake Assessment Form still based on Axis categories for Diagnostic Impression.** Currently, we just ignore the other 4 Axis boxes, but it would be nice to remove them entirely as they, technically, no longer exist in that form.
- **Two consent forms.** We have two consent forms, one where the client agrees to our terms and consents to be treated. The other is where the client consents to be seen via telehealth. It seems like almost two years later, combining the two forms would make sense. Telehealth is not going anywhere.
- **Confidentiality information.** It concerns me that confidentiality is not discussed anywhere on these forms, outside of the new telemental health form. Combining the two consent forms would also correct this issue. (Side note: I also have my PDS, which my clients sign along with the intake packet).
- **A separate form for opt-in reminders.** While we are combing forms, I feel like it would be effortless to include a quick question about this on the consent form where they give us all of their contact information.
- **Delete extraneous information.** When my site does combine forms, it often forgets to delete requests for duplicate information. Case in point, we have the "Presenting Problem" in two places on our initial assessment form.
- **The ROI form is a little confusing, even for me.** After working in the apartment industry for eight years and signing contracts, I am rarely overwhelmed by reading through a form. However, our ROI form makes my head spin, so I can only imagine what it does to someone without my background. I think this form needs to be simplified, but I am not sure where to begin doing that since I still do not understand all of it. Maybe just a sentence on the insurance authorization form that allows them to list to whom they wish for us to release records.