

**AUGUSTA STATE UNIVERSITY**  
**College of Education**  
**Department of Educational Leadership Counseling and Special Education**  
**Counselor Education Program**

## **CASE CONCEPTUALIZATION PROJECT**

Counseling 6900 or 6920: Students will submit a case conceptualization on a student/client with whom they have counseled over the semester.

Students will write a case conceptualization paper on a client at their school or community site. They will meet with their client on at least 3 occasions to develop a relationship with the client and gain a deeper understanding of his/her problem(s). If meeting with school clients, if possible, students are encouraged to meet with the parent(s) the first time to obtain background information.

Upon completion of meeting with their clients, students will complete a case conceptualization paper that should be typed, *double-spaced*, and a minimum of 12 pages in length, including all of the pages in the attached Initial Intake Assessment form. The paper must include at least 4 references pertinent to treatment with this population written within the last 10 years and adhere to APA (American Psychological Association) guidelines, including a reference list at the end. Papers do not need to include running heads or an abstract. Papers will be graded on the students' ability to accurately assess their client and develop an effective treatment plan, ability to summarize main points and follow the established guidelines, thoughtfulness of responses, staying within page and format guidelines, clarity of expression, and organization of ideas.

**Pertinent background and demographic information about the client:** For this section, as students interview their clients, they will obtain the information necessary to complete the Initial Intake/Assessment Form. Students will submit the completed Initial Intake/Assessment form as part of their final Case Conceptualization. In class we will discuss the kinds of questions to ask to obtain the information. Students will type out each section of the form in essay format.

## INITIAL INTAKE / ASSESSMENT FORM

Course Number / Title: \_\_\_\_\_

Student Name: \_\_\_\_\_

### PART 1: General Client Information and History

Name: \_\_\_\_\_ Date(s) of interview (s): \_\_\_\_\_  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 Sex: \_\_\_\_\_ Race: \_\_\_\_\_

**Description of the Presenting Problem:** Why is the client/family seeking services? Onset, possible causes, duration, intensity, fluctuations in severity?

**Mental Health History:** Include previous inpatient/outpatient psychiatric treatment, family history of mental illness, or homicidal/suicidal behavior.

**Social/Family History:** Include parents, children, siblings, marriages, divorces, and other family backgrounds.

**Medical History:** Include allergies, previous/current medications, physical impairments, surgeries, special diets, family history, or other pertinent medical information.

#### Persons in Last Household

Name	Sex	Age	Occupation	Relationship

**Substance Abuse/Use History:** Include abuse or use by the individual or family member(s). Describe patterns of alcohol and drug use. How much? How often?

**Community Support:** Describe problems in the following areas: Living arrangements, life skills, social supports, vocational/educational, financial/legal, leisure/recreational.

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**Developmental History:** Include pregnancy, labor, delivery, developmental milestones—walking, talking, toilet training, childhood injuries (if client is a child).

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**Educational History (if client is a child)**

<b>School(s) Attended</b>	
<b>Grade Completed</b>	
<b>Regular Classroom Placement?</b> If no, list all educational services provided:	
<b>Any repeated grades?</b> If yes, list and explain.	
<b>Suspensions / expulsions?</b> If so, describe.	
<b>List academic grades</b> (last years and most recent report card)	
<b>Testing</b> (achievement, etc.)	

**Assessment History and Other Significant Information (genogram and other)**

<b>Parent-child interaction observed during intake:</b>	
<b>Previous diagnostic instruments with approximate dates of administration</b> (i.e., psychological, educational, language, etc.):	
<b>Functional Assessment:</b>	
<b>Instrument Used:</b>	
<b>Date Given:</b>	

<b>Scores /Comments:</b>	
<b>Previous Therapy or Contact with Other Community Agencies</b>	
<b>List All:</b>	
<b>Additional Comments:</b> What else did you learn about the client which may positively or negatively impact his/her future:	

Mental Status		
	✓	Further Explanation
<b>SPEECH:</b>		
Appropriate		
Slowed		
Mechanical		
Rapid		
Other		
<b>BEHAVIOR:</b>		
Appropriate		
Withdrawn		
Bizarre		
Volatile		
Other		
<b>APPEARANCE:</b>		
Appropriate		
Disheveled		
Unclean		
Inappropriately dressed		
Other		
<b>MOOD:</b>		
Appropriate		
Manic		
Depressed		
Labile		
Irritable		

Other		
<b>AFFECT:</b>		
Appropriate		
Flat		
Labile		
Other		
<b>ORIENTATION:</b>		
Place		
Time		
Person		
Situation		
Other		
<b>THOUGHT CONTENT:</b>		
Appropriate		
Incoherent		
Obsessive		
Delusional		
Hallucinations		
Paranoid		
Other		
<b>MEMORY:</b>		
Appropriate		
Repressed		
Confused		
Other		
<b>INTELLIGENCE:</b>		
Average		
Above average		
Below average		
Other		
<b>JUDGEMENT/INSIGHT:</b>		
Appropriate		
Impaired		
Suicidal		
Homicidal		
Other		
<b>SLEEP:</b>		
Appropriate		
Disturbed		
<b>APPETITE:</b>		
Appropriate		
Disturbed		

**Part 2: Diagnostic Criteria, Characteristics and/or Dynamics Exhibited by the Person in This Particular Situation.** Complete the Multiaxial Diagnosis below. In essay format below this section, provide information about the symptoms you observed or heard from the client and the specific criteria which led you to the diagnosis given. If the client does not meet criteria for the formal diagnosis, discuss the pertinent issues for this client, and how you came to see these issues as the most important based on the information you obtained in the session.

Diagnosis Impression		
	Code	Title
Axis I		
Axis II		
Axis III (optional)		
Axis IV (optional)		
Axis V		
Observations and rationale for diagnosis given:		

**Part 3: Reasonable Treatment Goals, Both Long-Term and Short Term:** Use the format provided. Your goals should be written in behavioral terms; in other words, what will your client be doing or thinking or saying at the end of treatment so that you and he/she will know that he/she has met the goals? Start with "*The client will be able to . . .*" for each goal and objective listed.

<b>TREATMENT PLAN</b>
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Name: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Strengths:</b>	
<b>Statement of Problem</b> (include symptoms, complaints, duration, and frequency)	
<b>Problem #1:</b>	
<b>Problem #2:</b>	
<b>Problem #3:</b>	

Goals and Objectives – What will client accomplish in measurable terms?	
Goal #1:	
1a.	
1b.	
Goal #2:	
2a.	
2b.	
Goal #3:	
3a.	
3b.	

**PART 4: Your Theoretical Orientation and Coinciding Intervention**

**Strategies.** Based on your research findings about treatment strategies with persons with this diagnosis or these particular issues, tell about some of the best practice interventions which could be used most successfully with your client. You should include at least FOUR references pertinent to treatment with this population written within the last 10 years. Two of these references will be from professional journals describing interventions used successfully with conditions similar to those of your client. Two may be activities from other sources which you believe may be helpful. *Describe how your treatment strategies relate to your theoretical perspective and what impact the client's culture may play in the counseling process.*