

Brenda Lee Roberts, M. Ed., LPC

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Two Energy Square
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972-672-0038

To: _____ Date: _____

Please return this form to **BRENDA LEE ROBERTS** at the address listed above.

This form is provided for your convenience in responding to requested mental health information about the client identified below. **If necessary, please attach any additional written narrative.** *Copies of the client's records, except for psychiatric or psychological evaluations, admission/discharge summaries, or psychosocial reports are not required unless specifically applicable or requested.*

CLIENT'S NAME: _____ DOB _____

1. Referral source: _____
2. Is counseling/treatment ordered? _____
3. Presenting problem: _____
4. Date of initial appointment? _____
5. Dates of subsequent appointments: _____

6. Length of time therapy was provided? (or estimated length of stay if therapy is current)

7. Therapy schedule? _____ weekly _____ bi monthly _____ monthly _____ other
If other, please explain: _____
8. Types of therapy utilized? ___ individual ___ group ___ family ___ play ___ couple
9. Diagnosis: (Please use DSM-IV terminology rather than codes and please provide the client's symptomology)
Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____ current GAF _____ previous year GAF
(GAF- Global Assessment of Functioning)
10. Please list the client's issues and goals for therapy and his/her current status regarding each goal and/or issue. (If client has ceased therapy, please provide an overview of his/her experience)

11. Please list your goals and/or issues as a treatment provider for this client and his/her current status regarding each goal. (If client has ceased therapy, please provide an assessment, client's reason for termination and your prognosis)

12. Overall, is the client compliant with therapy? _____
Why or why not?

13. Have any outside referrals been made? To whom and why?

14. Is the client on medication? _____ If so, what are they taking?

Name of Med	Dosage	Frequency	Reason for taking
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. Is the client compliant with his/her medication regime? _____

16. If the client is an adult, please provide an assessment of his/her parenting skills?

17. Have you observed the client and/or the other parent with the children? _____

18. If the client is a child or adolescent, what is his/her current level of functioning?

19. Who has been involved in the child's therapeutic process? _____

20. Has any abuse or neglect been identified? _____ If so, what specific issues are you aware of? _____

21. Are there any current issues, needs or recommendations related to the client that are not currently being addressed? _____

