SYRACUSE UNIVERSITY
Counseling and Human Services

CASE STUDY FORMAT
For Practicum/Internship

Client Pseudonym ______________________________________ Date ____________________

Counselor Name ____________________________________________

Instructor ________________________________________________

Dates client has been seen by counselor thus far ____________________

1. Demographic description of client

Describe the client in terms of age, gender, cultural background, race, socioeconomic status, sexual orientation, religion, occupation/grade level, marital/family status, education

2. Presenting problem

Indicate referral source (e.g., parent, teacher, dean, resident director, self). One to two sentences about what brought the client to counseling. If the referral source is someone other than the client – state the referral sources rationale, as well as the client’s view of the reason to attend counseling.

3. Interview affect, behavior, and mental status

How does the client appear to you (grooming, dress, voice, tone, mood)? Has this been consistent or changed throughout sessions?

4. History

Present the history as objectively as possible. Facts may be collected from various sources – the client her/himself, significant others, records, referral sources. Let the facts speak for themselves. Do not interpret them. Use verbatim quotes from the client and others with knowledge of the client to capture significant statements.

   a. History of presenting problem

   Estimated date of onset, concurrent events, intensity, frequency, changes in symptoms. How long has this been going on? How often? Magnitude? Use quotes.

   b. Family history

   Past and present. Include marital status of parents and any dates of family structure changes or deaths. Include a description of relationships with family members, living arrangements, parents’ occupations, genogram. Include statement affirming/denying substance abuse, physical abuse or sexual abuse among family members, if appropriate.
c. Social relationship history

Past and present. Include a statement affirming/denying any unwanted sexual experience, physical abuse, trouble with police. How are relationships with friends, peers, coworkers, teachers? How were they before the onset?

d. Academic/work history

Past and present. What was/is school like? Academic aspirations? How was experience and performance before the onset?

e. Medical history

Past and present medical conditions, hospitalizations, prescription medicines, problems with eating, sleeping, weight control, alcohol and substance abuse. When was the last physical?

f. Counseling history

For what issue(s)? Was this voluntary or involuntary? List provider names, addresses, dates of service. Include self-help groups like AA. Was permission attained to retrieve previous records – incorporate a summary of experiences.

5. Assessment/Diagnosis

Provide your understanding of the client’s problem based on an interpretation and synthesis of the information assembled on the client. In making your assessment/diagnosis include impressions of client strengths and weaknesses, dimensions of affective, cognitive, behavioral, and systemic issues and your concerns for the client. Give rationale by using the facts to justify your definitions of the problem. Use theory (including developmental and socio-cultural frameworks) to frame your discussion.

6. Treatment Plan/Recommendations

Based on the assessment and theory and practice related to client issues, how would you go about treating the client – What ought to be done, by whom, for how long?

a. What are the goals for counseling?

Process? Outcome?

b. What methods should be incorporated? What type of interventions will be used? What is the likely outcome if followed?

Individual counseling, group counseling, etc.? What is the theoretical basis for interventions (affective, behavioral, cognitive)?

c. What adjunct services could be utilized?

Who else could be involved in working with the client (school nurse, teacher, special education teacher, gay and lesbian support group, etc.)

d. What are relevant ethical and legal considerations regarding client, assessment, and plan?

e. What is prognosis (favorable, marginal, good, excellent, etc.)? What makes you think so?

f. What evidence will you collect to determine outcome?