Case Presentation Format Form
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/student in terms of age, gender/gender identity, affectional/sexual orientation, race, ethnicity, socioeconomic status, spirituality/religion affiliation, occupation/grade level, marital/family status, education, language preference, etc.

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

3. **Interview affect, behavior, and mental status**
   How does the client/student appear to you (e.g., grooming, dress, voice, tone, mood, memory, cognitions, suicidal ideation, homicidal ideation)? Has this been consistent or changed throughout sessions?

4. **Cultural Considerations**
   Explore how cultural identity information about the client/student and knowledge about their cultural group affiliations may impact their presenting concerns, help-seeking behavior, approach to counseling, and experience of counseling. Include considerations of critical issues/needs and counseling strategies for working with clients/students with your client's/student's same cultural identities.

   a. **What cultural biases might you have towards your client/student?** Identify how your cultural values, beliefs, attitudes, and knowledge influence your perspectives towards the client/student. (Writing "none" is an inadequate response).

   b. **What cultural biases might your client have towards you?** Identify how your client's/student's cultural values, beliefs, attitudes, and knowledge might influence their perspectives towards you. (Writing "none" is an inadequate response).

   c. **What cultural dynamics might enhance or impede your relationship with this client/student?** Identify how the interplay of cultural backgrounds (e.g., values, beliefs, attitudes, identities) between the counselor and client/student can impact working alliance and achievement of counseling goals.

5. **History**
   Present the history as objectively as possible. Facts may be collected from various sources – the client/student themself, significant others, records, and referral sources. Let the facts speak for themselves. Do not interpret them. Use verbatim quotes from the client/student and others with knowledge of the client/student 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.

6. **Assessment/Diagnosis**
Provide your understanding of the client's/student'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/student. 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.

7. **Treatment Plan/Recommendations**
Based on the assessment and theory and practice related to client/student issues, how would you go about treating the client/student – 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/student (school nurse, teacher, special education teacher, gay and lesbian support group, etc.)

d. **What are relevant ethical and legal considerations regarding client/student, 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?**