Clinical Case Consultation Prep Form

You receive the most benefits from clinical consultation when you take time to prepare for the consultation. This prep form will help you organize your thoughts and formulate questions about the case; as well as, provide important information about the client/history, presenting issues, and the relationship between client and you.

1. Client demographics and info:
   a. age, race, gender
   b. appearance, affect and mood
   c. current living arrangements
   d. present family relationships
   e. significant Family of Origin relationships
   f. marital/significant other relationship (current & past)
   g. works where and does what kind of work
   h. level of engagement with you and the process
   i. medications/for how long
2. Presenting Problem(s):
   a. What is the presenting problem, described in specific behavioral terms, including onset?
   b. What has been tried before, in therapy and/or by client? What has worked, what hasn’t worked?
   c. Currently working with other mental health providers or community agencies?

3. Assessment/Impressions
   a. What is your assessment of safety risks?
      i. Risk to self/others
      ii. Current/past attempts to harms self/others/suicide
      iii. Level of impulsivity
   b. Assessment for substance abuse?
   c. Assessment of relationship/attachment style?
   d. Assessment of client’s current level of functioning?
   e. Assessment of strengths and deficits
   f. Working diagnosis: Principal/primary diagnosis, provisional (if needed), other applicable diagnoses, including V codes
   g. Therapeutic approach/lens using to understand and work with client
   h. What is like to be in the room with the client?
   i. What do you like about this client? What do you think client likes about you?

4. What is your primary consultation question/concern?