Instructions - Case History, Formulation and Treatment Plan

Please ensure to protect your client's confidentiality

1) Case History

Suggested # of words: 500 or 1 single spaced page

☐ a) Client Information

i. Provide general demographic information, including age, gender, relationship status, educational background, employment status.

☐ b) Background information including relevant medical history

i. Provide relevant background information including any current or past medical issues that have relevance for the conceptualization, relevant developmental history, current or recent stressors.

☐ c) Mental health history and treatment history including medications

i. Provide a brief synopsis of the client's mental health history including any difficulty with substances or addiction, previous treatments, any hospitalizations, and other current treatments (medications, other psychological treatments, psychosocial interventions, support, self-help, etc.).

☐ d) Presenting Concerns

i. Provide an overview of presenting concerns, including the client's description of why they are seeking treatment and relevant symptoms. You may choose to include diagnostic considerations (only for clinicians who have the ability to diagnose), but this is optional.

☐ e) History of main concern/symptoms

i. Provide an overview of the course and trajectory of the presenting concerns / symptoms.

☐ f) Behavioural Observations

i. Provide indicators of mental status and relevant behavioural observations, including affect in session, suicidal or homicidal ideation, judgment, insight, and any other observations.

2) Case Formulation

Suggested # of words: 500 or 1 single spaced page

☐ a) Can include both a narrative WORKING HYPOTHESIS and / or diagram of your choosing

☐ b) Key elements:

i. Problem list
ii. Developmental factors, key experiences (PREDISPOSING factors)
iii. Cognitive factors (possibly including core beliefs, assumptions, images, conditional beliefs, automatic thoughts) (PERPETUATING factors)
iv. Behaviours (possibly including withdrawal, rumination, avoidance, reassurance, safety behaviours, compensation strategies, self-concealment strategies, etc.) (PERPETUATING factors)
v. Triggers for current episode (PRECIPITATING FACTORS)
vi. Client strengths and resilience (PROTECTIVE FACTORS)
vii. Alternative core beliefs
viii. Motivation for treatment
ix. Potential obstacles for change

3) Treatment Plan & Outcome

Suggested # of words: 500 or 1 single spaced page

☐ a) Treatment goals

i. Please describe the behaviourally operationalized goals that you and your client have agreed on for the client's course of CBT.

☐ b) General plan for treatment, including particular interventions

i. Please indicate what CBT interventions you used in treatment with a brief rationale for why you selected particular interventions

☐ c) Course of treatment, including number of sessions, obstacles, progress and outcome (including how progress was assessed / measured)