Please use the forms included in this packet to make copies for your client files. The included forms are:

1. Client Rights
2. Informed Consent For Counseling Services
3. Informed Consent For Counseling Services—Minor
4. Progress Notes
5. Client Intake Form
6. Release Of Information
7. Case Summary
8. Individual/Family Counseling Log
9. Group Counseling
10. Client Contact Log
11. Supervision Log
12. Supervised Practicum Experience Summary Of Hours
13. Student Counselor Self-Evaluation Of Practicum Experience

CLIENT RIGHTS

ABOUT COUNSELING

Counseling is a wellness process designed for the client (you or your minor child) to be deeply heard, explore ways to build upon his/her assets and strengths, and look for opportunities to overcome adversity.

THE STUDENT COUNSELOR

The counselor is a graduate student in the Counseling and Human Development Department at South Dakota State University enrolled in a Counseling Practicum course. These counseling services are provided at no cost.

The client's counselor will work with and support the client in what he/she is capable of doing for himself/herself.

Clients are encouraged to ask questions about his/her counseling experience. Clients have the right to refuse any services or request another counselor at any time. The counselor is trained to not impose any stereotypes of behavior, values, or roles related to age, gender, religion, race, disability, nationality, or sexual orientation on the client.

CLIENT RESPONSIBILITIES

Clients are asked to attend scheduled sessions, talk about his/her strengths and challenges as openly and honestly as possible, and if comfortable, participate in any tasks or homework assignments. Clients are also asked to give his/her counselor 24-hour notice if he/she is unable to attend a scheduled session.

EMAIL COMMUNICATION

Email may be used to schedule appointments with the permission of the client. However, email involving personal or clinical concerns between the client and counselors are strongly discouraged because the confidentiality of email messages cannot be guaranteed. In addition, counselors and staff may not be capable to receive or regularly monitor their email.

CONFIDENTIALITY

Client communication with his/her counselor is kept in confidence and will not be shared with anyone outside the counseling session, unless written authorization is given to the counselor or under a qualifying exception. The client is entitled to a copy of his/her records if requested; records are kept for seven years from the date of service then destroyed. Exceptions to confidentiality mandated or permitted by law include, but are not limited to:

1. If there is risk of foreseeable harm to any person (the client or another identified person). SDCL 36-32-27(2).
2. When there is reason to suspect that a minor, disabled, or elderly individual is in danger of being abused or neglected, we are legally required to report this to the Department of Social Services. SDCL 22-46-9, 26-8A-3, and 36-32-27.
3. If a court of law or federal security entity lawfully orders the release of certain information about a client we are legally required to comply with this order (although we work to release the minimum information needed).
4. Professional standards recommend confidential consultation within the CHRD program to ensure quality care.
5. If clients are deemed to have a disease known to be both communicable and fatal, the counselor is justified in disclosing information to person(s) who may be at high risk of contracting the disease.

EMERGENCY

In the event of an emergency (e.g. threat to safety), the client must contact SDSU Counseling Services (605-688-6146) or the University Police Department (605-688-6146; from campus phone dial 111). Please do not email, text, or call the counselor-in-training.

INFORMED CONSENT FOR COUNSELING SERVICES

_____ I am aware that my counselor is a student working with a small practicum class and faculty supervisor; as such, material from my session may be reviewed and/or discussed with persons in that group as needed to provide supervision, treatment recommendations, and academic review.

_____ I understand that all information disclosed within sessions is confidential and will not be shared with anyone outside the counseling session unless I give written authorization to my counselor or under a qualifying exception mandated or permitted by law:

_____ If there is a serious risk of foreseeable harm to any person;

_____ When there is reason to suspect that a minor, disabled, or elderly individual is in danger of being abused or neglected;

_____ If a court of law or federal security entity orders the release of certain information; and

_____ I understand my interviews will be recorded, observed, and reviewed for the purpose of graduate student training and clinical supervision. The recordings are treated confidentially and erased after being reviewed. Concerns I have about recordings will be addressed to my student counselor. I understand I will not be recorded without my permission:

_____ I give permission to be recorded

_____ I DO NOT give my permission to be recorded

_____ I understand there is a possibility of risks and benefits that may occur in counseling. Counseling may involve the risk of remembering unpleasant events and arouse strong, emotional feelings. Counseling can also affect relationships with significant others. The benefits from counseling may be realized in an improved ability to relate with others; a clearer understanding of self, values, goals; and/or evidence of making healthy choices that lead to increased productivity and well-being.

_____ I understand that sessions may not fully meet my needs and as a result, a referral may be necessitated to more appropriately meet my needs and goals.

_____ I have the right to ask any questions about the counseling process (i.e., student qualifications, time limits, philosophy of promotion change, techniques utilized, etc.) or any other question with the counselor.

_____ I realize I have the right not to engage in treatment procedures.

_____ I may terminate counseling at any time.

_____ I have received, read, and understand my Client Rights.

_____ In the event of an emergency (e.g. threat to safety), I understand that I should not email, text, or call the counselor-in-training. I understand that I need to contact SDSU Counseling Services (605-688-6146) or the University Police Department (605-688-6146; from campus phone dial 111).

By signing below, I acknowledge that I am within legal capacity and give my consent to voluntarily accept the rights and responsibilities as indicated above.

Client Printed Name/Date:_____ Client Signature/Date:_____

Student Counselor Printed Name/Date:_____ Student Counselor Signature/Date:_____

INFORMED CONSENT FOR COUNSELING SERVICES—MINOR

_____ I am aware that my child's counselor is a student counselor trainee working under the supervision of their faculty supervisor and my child's school counselor.

_____ I understand that information from my child's session may be reviewed or discussed with persons in that group as needed to provide supervision, treatment recommendations, and academic review.

_____ I understand that all information disclosed within sessions is confidential and will not be shared with anyone outside the counseling session unless I give written authorization to the student counselor or under a qualifying exception mandated or permitted by law:

_____ If there is risk of foreseeable harm to any person;

_____ When there is reason to suspect that a minor, disabled, or elderly individual is in danger of being abused or neglected;

_____ If a court of law or federal security entity orders the release of certain information; and

_____ I understand my child's interviews will be recorded, observed, and reviewed for the purpose of graduate student training and clinical supervision. The recordings are treated confidentially and erased after being reviewed. Concerns I have about recordings will be addressed to my child's student counselor. My child will not be recorded without my permission:

_____ I give permission for my child to be recorded.

_____ I DO NOT give my permission for my child to be recorded.

_____ I understand there is a possibility of risks and benefits that may occur in counseling. Counseling may involve the risk of remembering unpleasant events and arouse strong, emotional feelings. Counseling can also affect relationships with significant others. The benefits from counseling may be realized in an improved ability to relate with others; a clearer understanding of self, values, goals; and/or evidence of making healthy choices that lead to increased productivity and well-being.

_____ I understand that sessions may not fully meet my child's needs and as a result, a referral may be necessitated to more appropriately meet my needs and goals.

_____ I have the right to ask any questions about the counseling process or any other question with the counselor (i.e., student qualifications, time limits, philosophy of promotion change, techniques utilized, etc.)

_____ I realize my child has the right not to engage in treatment procedures

_____ I may terminate counseling at any time

_____ I have received, read, and understand my child's Client Rights.

By signing below, I acknowledge that I am within legal capacity and legal guardian of the minor named below. I give my consent and voluntarily accept the rights and responsibilities as indicated above.

_____
Minor's Printed Name

_____
Legal Guardian's Printed Name Relationship to Child

_____ _____ _____
Legal Guardian's Signature Date Student Counselor Signature/Date

PROGRESS NOTES

Client ID _____ Student Counselor _____ Date _____

DESCRIPTION OF CLIENT'S PRESENTING PROBLEM

Subjective _____

Objective _____

MENTAL STATUS

Appearance	☐ Groomed ☐ Casual ☐ Good Hygiene ☐ Disheveled ☐ Body Odor ☐ Unusual
Motor Activity	☐ Relaxed ☐ Restless ☐ Sedated ☐ Threatening ☐ Other
Interpersonal	☐ Cooperative ☐ Oppositional ☐ Defensive ☐ Withdrawn ☐ Other
Mood	☐ Normal/Stable ☐ Anxious ☐ Depressed ☐ Angry ☐ Euphoric ☐ Irritable ☐ Elevated
Affect	☐ Normal Expression ☐ Blunted ☐ Restricted ☐ Flat ☐ Labile
Attention/Concentration	☐ Distractible ☐ Hyper-vigilant ☐ Poor
Speech	☐ Normal ☐ Pressured ☐ Slow ☐ Incoherent ☐ Circumstantial
Thought Process	☐ Normal ☐ Suicidal Ideation ☐ Homicidal Ideation ☐ Other
Thought Content	☐ Normal ☐ Hallucinations ☐ Delusions ☐ Ideas of Reference ☐ Obsessions ☐ Grandiosity ☐Flight of Ideas ☐ Loose Associations
Judgment	☐ Good ☐ Fair ☐ Poor ☐ Impulsive
Insight	☐ Good ☐ Fair ☐ Poor

THERAPEUTIC INTERVENTION

ASSESSMENT *(I.E. PROGRESS TOWARDS GOALS, SYMPTOM REDUCTION/INCREASE AND MENTAL STATUS, TEST REPORTS)*

PLAN FOR NEXT SESSION (INCLUDES HOMEWORK ASSIGNMENT)

CLIENT INTAKE FORM

Complete only if client participates in more than three sessions.

Client ID _____ Student Counselor _____ Date _____

PRESENTATION

Demographics (includes age, ethnicity, gender, grade, family and living situation) _____

Presenting Problem (a paragraph plus -if applicable- the referral source) _____

Circumstances of Presenting Problem (include estimated date of onset and concurrent events (triggers); intensity, frequency, and changes. Include the mention of other personal issues)

Interview Affect, Behavior, and Mental Status

PSYCHOSOCIAL DEVELOPMENT

Family History *(past and present –include description of relationships with family members, client's present living arrangements, parents' occupations; this includes statements affirming/denying family alcoholism, substance abuse, physical or sexual abuse; explain)*

Social and Personal Development *(Include client's development in terms of social skills and other developmental tasks appropriate for his/her age, relevant test results, interaction with school personnel)*

Academic Situation *(Include strengths and weaknesses in different course work, overall GPA, client's academic and career aspirations, relevant test results)*

Medical History *(past and present –Include statement affirming/denying any medical conditions, hospitalizations, prescription medicines [types, dose, and frequency], problems with eating and/or weight control, problems with alcohol and/or substance abuse)*

Counseling History *(briefly describe and list names, addresses, and estimated dates of service)*

ASSESSMENT

Include impressions of strengths and weaknesses, concerns calling for therapeutic intervention, treatment modalities and adjunct services which may be helpful to the client.

TREATMENT PLAN

Clients understanding of goals, methods, and approximate duration of counseling.

Student Counselor Printed Name Date

Student Counselor Signature

Practicum Supervisor Signature

RELEASE OF INFORMATION

_____ I hereby authorize the department, organization or individual named below to mutually exchange specified information concerning me and my care. I voluntarily authorize the disclosure of health care information from my record. I authorize South Dakota State University's Counseling and Human Development Department to receive or disclose information from/to:

Name	Title
Organization	Mailing Address
Phone Number	City, State, and Zip Code

_____ I understand that the information in my records may contain information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health services, and/or alcohol and drug abuse.

_____ I understand that I may revoke this authorization at any time.

_____ I understand that I have the right to refuse to sign this authorization and am not required to sign this form to receive treatment or be eligible for services.

_____ I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).

PURPOSE OF DISCLOSURE

RECORDS TO RELEASE *(CHECK ALL THAT APPLY)*

Attendance	Counseling		Medical	
☐ Extra Credit Session	☐ History	☐ Progress Notes	☐ History & Physical	☐ Progress Notes
	☐ Treatment Plan	☐ Discharge Summary	☐ Treatment plan	☐ Discharge Summary
	☐ Assessments (specify)	☐ Other (specify)	☐ Immunizations	☐ Laboratory Reports
	_____	_____	☐ Prescription Records	☐ Nutrition records
			☐ Assessments (specify)	☐ Other (specify)
			_____	_____

_____ I understand that this authorization is not to exceed six months and expires on _____ . NOTE: if no date is given, this authorization is only good for the purpose and date contained herein).

Client/Legal Representative's Printed Name	Date	Witness' Printed Name
Client/Legal Representative's Signature		Witness' Signature

Adapted for use with practicum students by permission from the Student Health and Counseling Services at South Dakota State University

CASE SUMMARY

Client ID _____ Intake Date _____ End Date _____ Number of Sessions _____

SERVICES PROVIDED

☐ Individual Counseling

☐ Group Counseling

☐ Couples Counseling

☐ Family Counseling

PROGRESS SUMMARY (I.E. ISSUES DISCUSSED, PROGRESS MADE, ETC.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DISPOSITION/RECOMMENDATIONS AND AFTERCARE/REFERRALS

☐ Closed; no referral sessions completed. This is a mutual decision between client and student counselor.

☐ Closed; referred to an on-campus resource or off-campus agency.

☐ Client withdrew or stopped attending without notice.

☐ Other _____

_____
Student Counselor Printed Name Date

_____
Student Counselor Signature

_____
Practicum Supervisor Signature

INDIVIDUAL/FAMILY COUNSELING LOG

Please complete the following by assigning each client or family an ID and then recording the number of sessions and amount of time provided to each.

Example: Sally Smith = Client #001. She had 4 sessions; each session was 1.5 hours long, for a total of 6 hours.

Client/Family Number	Number of Sessions	Session Length	Total Service Hours	First Session Date	Last Session Date

Student Counselor Printed Name Date

Student Counselor Signature

Practicum Supervisor Signature

GROUP COUNSELING

Complete this form for each Group session conducted; make additional copies as needed.

GROUP ID:_____

Name/Nature of Group _____

Number of Participants _____ Session Length _____ Begin Date _____ End Date_____ Total Hours _____

Summary

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Student Counselor Printed Name Date

Student Counselor Signature

Practicum Supervisor Signature

CLIENT CONTACT LOG

Client ID _____ Phone _____ Alternate Phone _____

Email _____ Student Counselor _____

Date Contacted	Comments

SUPERVISION LOG

Student Counselor _____ Practicum Supervisor _____

Week	Date	Individual Supervision	Group Supervision
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

SUPERVISED PRACTICUM EXPERIENCE SUMMARY OF HOURS

Student Counselor _____ Semester _____ Year_____

DIRECT SERVICE HOURS

Individual Counseling....._____

Group Counseling....._____

SUPERVISION HOURS

Individual/Triadic Supervision....._____

Group Supervision....._____

OTHER RELEVANT HOURS*

Examples of "Other Relevant Experience Hours" include conferences, workshops, service learning activities, and etc. Experience must be pre-approved with your Practicum supervisor; proof of attendance and reflection paper may be required.

....._____

....._____

....._____

....._____

TOTAL HOURS..... _____

Student Counselor Signature Date

Practicum Supervisor Signature Date

STUDENT COUNSELOR SELF-EVALUATION OF PRACTICUM EXPERIENCE

Student Counselor _____ Semester _____ Year_____

Take a moment to reflect upon your Practicum experience. How would you rate yourself on the following criteria? Use the following scale:

5: I reliably demonstrate this more than is expected of a Practicum student
4: I do this most of the time that can be expected from a Practicum student
3: I do this to an average degree for a Practicum student
2: I accomplished once in a while
1: I hardly ever accomplished this

Criteria	5	4	3	2	1
Timely management of the tasks and responsibilities in arranging and conducting sessions					
Ability to establish and keep rapport with clients					
Demonstration of effective communication					
Demonstration of informed judgment					
Demonstration of non-judgmental as well as non-discriminatory attitudes and behaviors					
Demonstration of appropriate personal and professional boundaries.					
Willingness to share and to look at personal feeling and processes, as well as an ability to separate personal issues from the counseling process					
Evidence of social appropriateness and flexibility, including an ability to flexibly apply a variety of counseling skills and strategies in response to client needs.					
Recognition of personal strengths and weaknesses, including the willingness to accept and use constructive criticism.					
Evidence of empathy, acceptance, respect, and understanding of human nature.					
Evidence of attention to ethical and professional responsibilities, including professional liability insurance.					
Ability to acknowledge personal limitations and to determine an appropriate course of action when limitations are reached.					
Ability to promote change					

Student Counselor Signature Date

Practicum Supervisor Signature Date