

**CLINICAL  
OUTCOMES in  
ROUTINE  
EVALUATION**

**END OF  
THERAPY  
FORM v.2**

<b>Site ID</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>Number of sessions planned</b>	<input type="text"/> <input type="text"/> <input type="text"/>
	letters                  numbers		
<b>Client ID</b>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<b>Sub Codes</b>	<b>Therapist ID</b>	<b>SC4 numbers</b>	<b>SC5 numbers</b>
	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<b>Date therapy commenced</b>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>
	D    D                  M    M                  Y    Y    Y    Y		
<b>Date therapy completed</b>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>
	D    D                  M    M                  Y    Y    Y    Y		

**What type of therapy was undertaken with the client?** *Please tick as many boxes as appropriate*

Psychodynamic	<input type="checkbox"/>	Person-centred	<input type="checkbox"/>
Psychoanalytic	<input type="checkbox"/>	Integrative	<input type="checkbox"/>
Cognitive	<input type="checkbox"/>	Systemic	<input type="checkbox"/>
Behavioural	<input type="checkbox"/>	Supportive	<input type="checkbox"/>
Cognitive/Behavioural	<input type="checkbox"/>	Art	<input type="checkbox"/>
Structured/Brief	<input type="checkbox"/>	Other ( <i>specify below</i> )	<input type="checkbox"/>

**What modality of therapy was undertaken with the client?** *Please tick as many boxes as appropriate*

Individual	<input type="checkbox"/>	Family	<input type="checkbox"/>
Group	<input type="checkbox"/>	Marital/Couple	<input type="checkbox"/>

**What was the frequency of therapy with the client?**

More than once weekly	<input type="checkbox"/>	Less than once weekly	<input type="checkbox"/>
Weekly	<input type="checkbox"/>	Not at a fixed frequency	<input type="checkbox"/>

**Which of the following best describes the ending of therapy?**

<b>Unplanned</b> <input type="checkbox"/>	<b>Planned</b> <input type="checkbox"/>
Due to crisis <input type="checkbox"/>	Planned from outset <input type="checkbox"/>
Due to loss of contact <input type="checkbox"/>	Agreed during therapy <input type="checkbox"/>
Client did not wish to continue <input type="checkbox"/>	Agreed at end of therapy <input type="checkbox"/>
Other unplanned ending ( <i>specify below</i> ) <input type="checkbox"/>	Other planned ending ( <i>specify below</i> ) <input type="checkbox"/>

### Review of Identified Problems/Concerns

Severity	Therapy Issue	Severity	Therapy Issue
<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Trauma/Abuse	<input type="checkbox"/>
<input type="checkbox"/> Anxiety/Stress	<input type="checkbox"/>	<input type="checkbox"/> Bereavement/Loss	<input type="checkbox"/>
<input type="checkbox"/> Psychosis	<input type="checkbox"/>	<input type="checkbox"/> Self esteem	<input type="checkbox"/>
<input type="checkbox"/> Personality Problems	<input type="checkbox"/>	<input type="checkbox"/> Interpersonal/relationship	<input type="checkbox"/>
<input type="checkbox"/> Cognitive/Learning	<input type="checkbox"/>	<input type="checkbox"/> Living/Welfare	<input type="checkbox"/>
<input type="checkbox"/> Physical Problems	<input type="checkbox"/>	<input type="checkbox"/> Work/Academic	<input type="checkbox"/>
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/> Other <i>(specify below)</i>	<input type="checkbox"/>
<input type="checkbox"/> Addictions	<input type="checkbox"/>	<input type="text"/>	

Risk	None	Mild	Mod	Sev
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harm to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal/Forensic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Contextual Factors	Poor	Moderate	Good
Motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working Alliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Mindedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Benefits of Therapy	Improved				Improved		
	Yes	No	Not addressed		Yes	No	Not addressed
Personal insight/understanding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Control/planning/decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expression of feelings/problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Subjective well-being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exploration of feelings/problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coping strategies/techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Day to day functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to practical help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Personal relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other benefits	<input type="checkbox"/>						
<i>Tick box and then specify below</i>							
<input type="text"/>							

Has contact with this service resulted in a change of medication? Yes  No  Not applicable

If yes, is this change likely to be of benefit to the client? Yes  No

Details of change: Started  Discontinued  Increased  Decreased  Modified

Has the client been given a follow-up appointment? Yes  No

Number of months until appointment