CLINICAL OUTCOMES in ROUTINE EVALUATION

END OF THERAPY FORM V.2

Site ID

Client ID letters numbers

Sub Codes Therapist ID SC4 numbers SC5 numbers

Date therapy commenced D D / M M / Y Y Y Y

Date therapy completed D D / M M / Y Y Y Y

Number of sessions planned

Number of sessions attended

Number of sessions unattended

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

Psychodynamic	☐	Person-centred	☐
Psychoanalytic	☐	Integrative	☐
Cognitive	☐	Systemic	☐
Behavioural	☐	Supportive	☐
Cognitive/Behavioural	☐	Art	☐
Structured/Brief	☐	Other *(specify below)*	☐

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

Individual	☐	Family	☐
Group	☐	Marital/Couple	☐

What was the frequency of therapy with the client?

More than once weekly	☐	Less than once weekly	☐
Weekly	☐	Not at a fixed frequency	☐

Which of the following best describes the ending of therapy?

Unplanned ☐

Due to crisis	☐
Due to loss of contact	☐
Client did not wish to continue	☐
Other unplanned ending *(specify below)*	☐

Planned ☐

Planned from outset	☐
Agreed during therapy	☐
Agreed at end of therapy	☐
Other planned ending *(specify below)*	☐

Review of Identified Problems/Concerns

Severity		Therapy Issue	Severity		Therapy Issue
☐	Depression	☐	☐	Trauma/Abuse	☐
☐	Anxiety/Stress	☐	☐	Bereavement/Loss	☐
☐	Psychosis	☐	☐	Self esteem	☐
☐	Personality Problems	☐	☐	Interpersonal/relationship	☐
☐	Cognitive/Learning	☐	☐	Living/Welfare	☐
☐	Physical Problems	☐	☐	Work/Academic	☐
☐	Eating Disorder	☐	☐	Other *(specify below)*	☐
☐	Addictions	☐			

Risk

	None	Mild	Mod	Sev
Suicide	☐	☐	☐	☐
Self Harm	☐	☐	☐	☐
Harm to others	☐	☐	☐	☐
Legal/Forensic	☐	☐	☐	☐

Contextual Factors

	Poor	Moderate	Good
Motivation	☐	☐	☐
Working Alliance	☐	☐	☐
Psychological Mindedness	☐	☐	☐

Benefits of Therapy

	Improved Yes	Improved No	Not addressed
Personal insight/understanding	☐	☐	☐
Expression of feelings/problems	☐	☐	☐
Exploration of feelings/problems	☐	☐	☐
Coping strategies/techniques	☐	☐	☐
Access to practical help	☐	☐	☐
Other benefits	☐		

Tick box and then specify below

	Improved Yes	Improved No	Not addressed
Control/planning/decision making	☐	☐	☐
Subjective well-being	☐	☐	☐
Symptoms	☐	☐	☐
Day to day functioning	☐	☐	☐
Personal relationships	☐	☐	☐

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

☐☐