CLINICAL
OUTCOMES in
ROUTINE
EVALUATION

THERAPY ASSESSMENT FORM v.2

Site ID (letters) (numbers)

Client ID

Sub Codes TH ID number | SC2 numbers | SC3 numbers

Referrer(s)

Age

Male ☐ **Female** ☐

Employment

Ethnic Origin

Referral date D D / M M / Y Y Y Y

First assessment date attended D D / M M / Y Y Y Y

Last assessment date D D / M M / Y Y Y Y

Total number of assessments

Previously seen for therapy in this service? Yes ☐ No ☐ **Episode**

Months since last episode

Is this a follow-up/review appointment? Yes ☐ No ☐

Relationships/support *Please tick as many boxes as appropriate*

- Living alone (not including dependents) ☐
- Living with partner ☐
- Caring for children under 5 years ☐
- Caring for children over 5 years ☐
- Living with parents/guardian ☐
- Living with other relatives/friends ☐
- Full time carer (of disabled/elderly etc) ☐
- Living in shared accommodation (eg lodgings) ☐
- Living in temporary accommodation (eg hostel) ☐
- Living in institution/hospital ☐
- Other ☐

Current/previous use of services for psychological problems?
Please tick as many boxes as appropriate

		Concurrent	< 12 mths	> 12 mths
Primary	GP or other member of primary care team (eg practice nurse, counsellor)	☐	☐	☐
Secondary	In primary care setting	☐	☐	☐
	In community setting	☐	☐	☐
	In hospital setting on sessional basis	☐	☐	☐
	Day care services (eg day hospital)	☐	☐	☐
	Hospital admission < = 10 days	☐	☐	☐
	Hospital admission > = 11 days	☐	☐	☐
Specialist	Psychotherapy/psychological treatments from specialist team (sessional)	☐	☐	☐
	Attendance at day therapeutic programme	☐	☐	☐
	Inpatient treatment	☐	☐	☐
Other	Counsellor in eg voluntary, religious, work, educational setting	☐	☐	☐

Is the client currently prescribed medication to help with their psychological problem(s)? Yes ☐ No ☐

If yes, please indicate type of medication:

Anti-psychotics (neuroleptics/major tranquillizers) ☐ Anti-depressants ☐ Anxiolytics/Hypnotics (minor tranquillizers) ☐ Other ☐

Brief description of reason for referral

Identified Problems/Concerns

	Severity	< 6 months	6-12 months	> 12 months	Recurring/ continuous
Depression	☐	☐	☐	☐	☐
Anxiety/Stress	☐	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐	☐
Personality Problems	☐	☐	☐	☐	☐
Cognitive/Learning	☐	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐	☐
Physical Problems	☐	☐	☐	☐	☐
Addictions	☐	☐	☐	☐	☐

	Severity	< 6 months	6-12 months	> 12 months	Recurring contin.
Trauma/abuse	☐	☐	☐	☐	☐
Bereavement/loss	☐	☐	☐	☐	☐
Self esteem	☐	☐	☐	☐	☐
Interpersonal/relationship	☐	☐	☐	☐	☐
Living/Welfare	☐	☐	☐	☐	☐
Work/Academic	☐	☐	☐	☐	☐
Other (*specify below*)	☐	☐	☐	☐	☐

Risk

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

ICD-10 CODES

	F/Z	Main code	Sub-code		F/Z	Main Code	Sub-code
1	☐	☐☐ .	☐	3	☐	☐☐ .	☐
2	☐	☐☐ .	☐	4	☐	☐☐ .	☐

What has the client done to cope with/avoid their problems? *Please tick, and then specify actions*

Positive actions ☐

Negative actions ☐

Assessment outcome ***(tick one box only)***

- Assessment/one session only ☐
- Accepted for therapy ☐
- Accepted for trial period of therapy ☐
- Long consultation ☐
- * Referred to other service ☐
- * Unsuitable for therapy at this time ☐

***If the client is not entering therapy give brief reason**