DOR COUNSELOR FORM

Client's Name: ________________________ **Client Company/Organization:** ____________________________

Assessed Problems:

Lifestyle:	**Work:**	**Psychological:**	**Abuse:**	**Addiction:**
___ Crisis	___ CISD	___ Anxiety	___ Emotional	___ Chemical Health
___ Family	___ Job Stress	___ Depression	___ Physical	___ Codependency
___ Financial	___ SAP/ DFWP	___ Grief	___ Sexual	___ Gambling
___ Legal	___ Supervisory Consult	___ Other Psychological		___ Sexual Addiction
___ Physical	___ Training Request			___ Other Addiction
___ Parenting	___ Work Performance			
___ Relationship	___ Other Job Related			
___ Stress				

Referral given for this client:

___ Addiction Treatment	___ Financial Counseling	___ Mental Health Tx	___ Physical Care	___ Union
___ Bibliotherapy	___ Human Resources	___ None	___ Police	___ Website
___ Couple/Fam. Therapy	___ Individual Therapy	___ Onsite Services	___ Support Group	___ Work/Life
___ Community Services	___ Legal Services	___ Org. Development	___ Training	___ Other

Presenting Problem: ____

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History/ Relevant Data: ____

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Action Plan. Include name and phone # for any referral: ____

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Date:________________

Time of Contact/Appointment:___________________

Counselors Signature: ______________________________

Time spent (record in .25 hours - i.e. 15 min = .25 hour):

Phone: ______

In Person: ______

No-Show: ______

Case Mgmt: ______

Are you closing the case? Y N Follow-up necessary? Y N Date of follow-up: ________________________

10/03