**Student Name:**      **Student ID #:**       **Date:**

**TYPE OF CONTACT**

[ ]  Individual [ ]  Group [ ]  Medication Check-In [ ]  MSWR/Separation Incident

[ ]  Consultation with:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Other

**MENTAL STATUS**

|  |  |  |  |
| --- | --- | --- | --- |
| Appearance | [ ]  Normal [ ]  Unusual | Danger to Self | [ ]  Yes [ ]  No |
| Speech | [ ]  Normal [ ]  Unusual | Danger to Others | [ ]  Yes [ ]  No |
| Cognition/Perception | [ ]  Normal [ ]  Unusual | Explain Unusual Items/Comments:          |
| Mood/Affect | [ ]  Normal [ ]  Unusual |
| Behavior  | [ ]  Normal [ ]  Unusual |

**INTERVENTIONS** *(Indicate primary intervention types utilized. Describe in summary of session.)*

|  |  |  |
| --- | --- | --- |
| [ ]  Assess/Info Gather | [ ]  Psychoeducation | [ ]  Motivational Interviewing |
| [ ]  Crisis Intervention | [ ]  Stress Management | [ ]  CBT/ACT |
| [ ]  Empathic Exploration | [ ]  Social Skill Training | [ ]  DBT/Mindfulness |
| [ ]  Decision Making | [ ]  Psychodynamic/Relational | [ ]  Other |

**SUMMARY** (*Include how the session ties into employability or the work environment for the student)*

**DIAGNOSTIC IMPRESSIONS, if indicated:**

**PROGRESS WITH TREATMENT GOALS**

[ ]  Marked Improvement [ ]  Some Improvement [ ]  Maintenance of Functioning [ ]  Symptoms Worse

**FUTURE TREATMENT/FOLLOW-UP PLAN**

**Signature and Title Date**

**Supervisor Signature and Title, if applicable Date**