Optum Health Services (Canada) Ltd.
4727 Hastings Street,
Burnaby, BC V5C 2K8

Confidential

CLIENT RECORD

(Notes must be legible to be legal)

Toll Free 1.800.663.9099 Tel 604.431.8200 Fax 604.432.1555 www.optum-ca.com

Client File #:_____

BIO-PSYCHOSOCIAL ASSESSMENT

Issues relevant to the presenting problem or that are identified as a concern:

WORK-RELATED ISSUES

- ❑ Balance of Work & Home Life
- ❑ Change / issues around reorganization
- ❑ Cultural diversity related
- ❑ Discrimination
- ❑ Employee – Management Conflict
- ❑ Environmental Concerns
- ❑ Harassment at Work
- ❑ Job Loss
- ❑ Peer Conflict
- ❑ Performance
- ❑ Quality or Quantity of Work
- ❑ Retirement
- ❑ Return to Work
- ❑ Trauma (Post-trauma)
- ❑ Violence
- ❑ Other_____

INDIVIDUAL ISSUES

- ❑ Anger Management
- ❑ Anxiety
- ❑ Depression
- ❑ Family of Origin
- ❑ Grief and Loss
- ❑ Isolation
- ❑ Life Transition
- ❑ Low Self-confidence / Poor Self-image
- ❑ Motor Vehicle Accident
- ❑ Panic Attacks
- ❑ Relationship Difficulties
- ❑ Sexuality
- ❑ Stress Management
- ❑ Suicidal Ideation
- ❑ Trauma (not work-related)
- ❑ Other_____

COUPLES ISSUES

- ❑ Adjustment Issues
- ❑ Affair (self)
- ❑ Affair (partner)
- ❑ Alcohol/Drug (partner)
- ❑ Communication / Conflict Resolution
- ❑ Infertility
- ❑ Grief and Loss
- ❑ Ill Partner(i.e.: chronic pain, cancer, MS)
- ❑ Separation / Divorce
- ❑ Stress
- ❑ Verbal Abuse
- ❑ Violence
- ❑ Other_____

FAMILY ISSUES

- ❑ Adolescent Behaviour
- ❑ Blended Family Issues
- ❑ Child Behaviour
- ❑ Effects of Relocation on Family
- ❑ Effects of Separation on Children
- ❑ Elder Care
- ❑ Family Member is Suicidal
- ❑ Family of Origin Issue
- ❑ Illness of Children
- ❑ Parenting Skills / Issues
- ❑ Transition to Parenthood
- ❑ Violence
- ❑ Other_____

ADDICTION ISSUES

- ❑ Alcohol Abuse
- ❑ Drug Abuse
- ❑ Gambling
- ❑ Internet
- ❑ Family History of Addiction Issues _____
_____(specify)

- ❑ Other _____
_____ (specify)

HEALTH ISSUES

- ❑ Disordered Eating
- ❑ Medical Problems / Illness
- ❑ Family History of Medical Problems / Illness _____
_____ (specify)
- ❑ Mental Health Illness
- ❑ Family History of Mental Health Issues _____
_____(specify)
- ❑ Other _____
_____ (specify)

LEGAL ISSUES

- ❑ _____ (specify)

FINANCIAL / SOCIOECONOMIC ISSUES

- ❑ _____ (specify)

- ❑ Medication: _____
_____
_____ (specify)

Date of Last Medical Exam: _____
Family Doctor: _____
Phone No.: _____

Additional Comments: _____

NOTES MUST BE LEGIBLE TO BE LEGAL

INITIAL ASSESSMENT & SERVICE PLAN

Client's assessed problem

_____

_____

_____

HISTORY OF assessed PROBLEM & OTHER RELEVANT INFORMATION
(Including social, educational, work-related, economic, legal variables)

_____

_____

Impact of assessed problem on work productivity and attendance

_____

_____

PREVIOUS OR CURRENT COUNSELLING (with whom? when?)

_____

RISK FACTORS

_____

OBSERVATIONS

Client: – client statements, beliefs and attitudes, in relation to **assessed problem**.

_____

_____

_____

Counsellor: – include observable and reported behaviours, strengths, and resources.

_____

_____

_____ GAF Score:_____

COUNSELLING GOALS (specific, short-term, solution-focused)

_____

_____

_____

COUNSELLING PLAN TO ACHIEVE GOALS STATED ABOVE

_____

_____

_____

Signature & credentials: _____ Date: _____

NOTES MUST BE LEGIBLE TO BE LEGAL

PROGRESS NOTES

Each entry must include:
- session number and type or contact type
- date and time of session/contact
- session attendee initials
- focus of the session/contact
- brief clinical impressions
- plan and/or homework
- discharge and follow-up information, as appropriate

At the end of each entry:
- signature & credentials
- date of writing

Type of session/contact *:*
in person – IP
telephone (client) – TC
telephone professional consultation – TP
telephone (workplace) - TW
clinical supervision – CS
referral resource consultation – RC
referral or client follow up – F/U
no show – NS
late cancellation - LC
other (specify) - O

DATE/TIME	SESSION/CONTACT	SESSION ATTENDEE INITIALS	
	Session No.:		
	Session or Contact Type:		
ISSUES/THEMES ADDRESSED			
Focus of session/contact:			
Brief clinical impressions:			
Plan and/or homework:			
Signature & credentials:		Date:	

DATE/TIME	SESSION/CONTACT	SESSION ATTENDEE INITIALS	
	Session No.:		
	Session or Contact Type:		
ISSUES/THEMES ADDRESSED			
Focus of session/contact:			
Brief clinical impressions:			
Plan and/or homework:			
Signature & credentials:		Date:	

NOTES MUST BE LEGIBLE TO BE LEGAL

PROGRESS NOTES (cont'd)

DATE/TIME	SESSION/CONTACT	SESSION ATTENDEE INITIALS	
	Session No.:		
	Session or Contact Type:		
ISSUES/THEMES ADDRESSED			
Focus of session/contact:			
Brief clinical impressions:			
Plan and/or homework:			
Signature & credentials:		Date:	
DATE/TIME	**SESSION/CONTACT**	**SESSION ATTENDEE INITIALS**	
	Session No.:		
	Session or Contact Type:		
ISSUES/THEMES ADDRESSED			
Focus of session/contact:			
Brief clinical impressions:			
Plan and/or homework:			
Signature & credentials:		Date:	
DATE/TIME	**SESSION/CONTACT**	**SESSION ATTENDEE INITIALS**	
	Session No.:		
	Session or Contact Type:		
ISSUES/THEMES ADDRESSED			
Focus of session/contact:			
Brief clinical impressions:			
Plan and/or homework:			
Signature & credentials:		Date:	

(Insert additional **Progress Notes** as needed)

NOTES MUST BE LEGIBLE TO BE LEGAL

CLOSING SUMMARY

Closing Date (mm/dd/yy): _____-_____-_____

Primary Counsellor: _____

Resolution: *(check one)*
____ Presenting problems resolved
____ Progress made
____ Progress made-Referral recommended
____ no further support requested
(includes clients that did not attend any sessions)

Counselling Type: *(check one most common)*
____ Individual ____ Couple ____ Family

Total # Sessions:
____ Attended
____ Missed
____ Cancelled

Complete only if the client is the employee

Outcome in the Workplace (<u>select one only</u>):
____ Improved Decision Making
____ Improved Work Relationships
____ Increased Concentration
____ Higher Morale
____ Higher Productivity Level
____ Reduced Absenteeism
____ Reduced Lateness
____ Returned to Work

____ Not Applicable (*Use only when client is not attending work*)

____ Family Member – not applicable

Suggested and Facilitated Referrals

Date of Referral	Referral Name / Organization	Telephone #	Referral Accepted	Follow-up at 2 weeks	Notes
			Y / N		
			Y / N		
			Y / N		
			Y / N		

<u>Changes in condition regarding presenting and/or assessed problems:</u>

_____

_____

_____

GAF Score at Initial Assessment: _____

GAF Score at Closing: _____

Change: _____

<u>Client reports achievement of counseling goals</u> ❑ yes ❑ partly ❑ no

If no, please explain: _____

<u>Recommended Action from EAP Provider:</u>

_____

_____

_____

_____

Client File Content Checklist

- ☐ Statement of Understanding (signed and witnessed)
- ☐ Client Questionnaire and AUDIT/DAST as needed
- ☐ Accessibility Survey
- ☐ Satisfaction Survey
- ☐ Biopsychosocial Assessment complete
- ☐ Initial Assessment & Service Plan complete
- ☐ Progress notes for each contact
- ☐ Supervision or Consultation recorded including recommendations and actions taken
- ☐ Release of Information - if necessary
- ☐ Referral Record complete - as appropriate
- ☐ Closing Summary complete (Resolution, Outcome Counselling Goals, Assessed Problems, Work Impact, Counsellor Signature/Credentials, Date)

CLOSING SUMMARY (cont'd)

Assessed Problems: (at closing) Please select **One Primary (P)** & **One Secondary (S)** Assessed Problem
i.e.: __**P**__ Grief / Bereavement & __**S**__ Family

*****please do not add categories*****

Addictions:
____ACOA
____Alcohol
____Drug
____Gambling
____Other

Family / Couple:
____Blended Family
____Childcare
____Couple
____Domestic Violence
____Eldercare
____Family
____Parenting
____Separation / Divorce

Personal / Emotional:
____Anger Management
____Anxiety
____Childhood Abuse
____Depression
____Eating Disorder
____Grief / Bereavement
____Health
____Life Transitions
____Relationship (non-family)
____Relocation
____Self-esteem
____Self-harm
____Sexuality Issues
____Stress Management
____Trauma / Critical Incident
____Other

Work Related:
____Anger Management
____Career Development
____Consultation
____Critical Incident – Work
____Harassment
____Job Loss
____Personal Effectiveness
____Retirement
____Return to Work
____Stress Concerns
____Work Life Balance
____Work Place Conflict
____Work Transitions

Work-Life Services
____Legal Consultation
____Financial Consultation
____Smoking Cessation
____Nutritional Coaching
____Childcare/Eldercare
____Wellness

Work Impact: (employees only)

Performance Impairment

At Initial Assessment:
- ❑ None
- ❑ Mild (not noted by the work environment)
- ❑ Moderate (noted by the work environment)
- ❑ Severe (remedial steps)
- ❑ Family Member – not applicable
- ❑ Employee – not attending work

At Closing:
- ❑ None
- ❑ Mild
- ❑ Moderate
- ❑ Severe

Absence

- ❑ None
- ❑ Mild (few hours)
- ❑ Moderate (1 to 5 days)
- ❑ Severe (Disability Leave)
- ❑ Family Member – not applicable
- ❑ Employee – not attending work

- ❑ None
- ❑ Mild
- ❑ Moderate
- ❑ Severe

Summary of Client Session Dates (including Late Cancellations &/or No Shows)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Optum's ***Accessibility Survey*** *given to client* ❒ Yes ❒ No
Satisfaction Survey *given to client* ❒ Yes ❒ No

Counsellor's Signature & credentials: _____ Date: _____