Formal Case Presentation Format

Case Presentation

I. Background Information (Relevant facts)

a. **Fictional name:** age, sex, relationship status, ethnicity, education, occupation, residence.

b. **Mental Status:** Cognitive functioning, appearance, dress, mood, orientation, contact with reality, affect.

c. **Chief Complaint/Presenting Problem:** Conditions and situation precipitating admission/visit.

d. **History of Presenting Problem & Treatment Episodes:** current condition, chemical use history.

e. **Medical, Physical & Mental Health History:** Hospitalizations, emergency room visits, treatment, diseases, preventive health care, and high –risk potentials.

f. **Social Assessment**

    1. Family of Origin: Description of family, functionality, generational issues.

    2. Primary Relationship: History, current, spouse's chemical use and functionality.

    3. Sexual History/Development: Development, preference, abused or abuser, HIV/STD risk.

    4. Trauma and Losses: Emotional, physical, and other.

    5. Social/Peer Relations: Support network, degree of social involvement and skills.

    6. Religion/Spiritual Orientation: Attitude, involvement, attendance, values, beliefs.

    7. Financial status: Problems, impact of chemical use and socioeconomic status.

g. **Legal Problems:** History, current status and pending charges.

h. **Vocation and/or Education:** Problems, performance, attitudes and plans.

i. **Collateral Information:** information from sources other than the client and past treatment records.

2. Diagnosis and Treatment

a. **Assessment and Diagnosis:** Summarize assessment and substantiate your diagnosis.

b. **Treatment Planning:** Describe the plan and course of treatment. Describe how the treatment plan will address the client's motivation for treatment, the client's problems, strengths, weaknesses, and culture. How was the client involved in the development of the treatment plan?

c. **Termination Plans:** Describe your plans for termination

3. Transference/Countertransference:

a. Discuss possible reactions the client is having, and your emotional reactions to this client/case.