Psychology Department



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**Case Formulation & Treatment Plan**

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| --- | --- | --- | --- |
| Client name: |  | Date of report: |  |
| Therapist: |  | Dates seen: |  |

**Referral Information**

Who is the client? Why were they referred to us? Who referred them?

**Case History**

A history of psych problems, including what precipitated the current need for services. Relevant developmental/medical/educational/social history should also be included.

**Case Formulation**

* Problem list
  + Comprehensive list of all client difficulties stated in concrete terms, across domains of
    - Psychological symptoms, Interpersonal difficulties, Occupational, Medical, Financial, Housing, Legal, & Leisure areas
* Diagnosis
  + DSM-IV-TR codes for all axes (Axis I & II diagnoses must have been justified in your above case history)
* Schemas/Behavioral contingencies
  + Particularly salient negative automatic thoughts and/or reinforcers/punishers maintaining current behavior
* Strengths & Assets
  + What in the client’s personality/history/social environment bodes well for treatment?
* Working hypothesis
  + This should describe relationships between items in the problem list, impact of negative schemas/behaviors on those problems (organismic variables), and origins or distal factors influencing current problems.

**Treatment Plan**

* Goals
  + Ways to solve items on the problem list, as well as means by which progress on each goal will be measured
* Modality
  + What type of therapy will be used? Be as specific as possible (e.g., “CBT focusing on exposure with response prevention per Soandso’s (1998) protocol” rather than “CBT”)
* Frequency
  + How often and for long will therapy occur
* Interventions
  + What will be taught and practiced in treatment?
* Adjunctive therapies
  + Referrals for medication/other types of therapy (OT, PT, SLT), etc.
* Obstacles
  + What things will make success difficult?

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