PROJECT # _____

Individual Crisis Counseling Services Encounter Log

OMB NO. 0930-0270
Expiration Date 01/31/2012

Provider Name _____ Provider # _____ Employee # _____

Date of Service (mm/dd/yyyy) _____ County Code of Service _____ Zip Code of Service _____

CHARACTERISTICS of ENCOUNTER

LOCATION of SERVICE (select one)

- ☐ school & child care (all ages through college)
- ☐ community center (e.g., government, recreation, social services)
- ☐ provider site (agency involved with CCP)
- ☐ workplace (e.g., office workers, public safety)
- ☐ disaster recovery center (e.g., FEMA, Red Cross)
- ☐ place of worship (e.g., church, synagogue, mosque)
- ☐ retail (e.g., restaurant, mall, shopping center, store)
- ☐ home (temporary or permanent; including friend or family homes; group homes; including houses, apartments, trailers, and other dwellings)
  - ☐ IF HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN < AGE 18 LIVE IN THIS HOME.
- ☐ phone counseling (15 minutes or longer, including "hot-lines" & "life-lines")
- ☐ medical center (e.g., doctor, dentist, hospital, mental health specialty)
- ☐ public place/event (e.g., street, sidewalk, town square, fair, festival, sports)
- ☐ other (specify in box) > _____

VISIT TYPE ☐ Individual ☐ Family (2 or more related individuals; please complete one form for each active participant.)

VISIT NUMBER ☐ 1st visit ☐ 2nd visit ☐ 3rd visit ☐ 4th visit ☐ 5th visit or more

DURATION ☐ 15-29 minutes ☐ 30-44 minutes ☐ 45-59 minutes ☐ 60 minutes or more

RISK CATEGORIES (select all that apply)

- ☐ family missing/dead
- ☐ friend missing/dead
- ☐ pet missing/dead
- ☐ home damage
- ☐ vehicle or major property loss
- ☐ other financial loss
- ☐ injured or physically harmed (self or household)
- ☐ life was threatened (self or household)
- ☐ witnessed death/injury (self or household)
- ☐ assisted with rescue/recovery (self or household)
- ☐ disaster unemployed (self or household)
- ☐ had to change schools (for children or youth)
- ☐ evacuated quickly with no time to prepare
- ☐ prolonged separation from family
- ☐ displaced from home 1 week or more
- ☐ past substance use/mental health problem
- ☐ pre-existing physical disability
- ☐ past trauma

DEMOGRAPHIC INFORMATION

Age (select one)

- ☐ preschool (0-5)
- ☐ child (6-11)
- ☐ adolescent (12-17)
- ☐ adult (18-39)
- ☐ adult (40-64)
- ☐ adult (65+)

Sex (select one)

- ☐ male
- ☐ female

Race (select one or more)

- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ White

Ethnicity (select one)

- ☐ Hispanic or Latino
- ☐ not Hispanic or Latino

Primary Language of Contact (select one)

- ☐ English
- ☐ Spanish
- ☐ other (specify in box)> _____

EVENT REACTIONS (select all that apply)

BEHAVIORAL

- ☐ Extreme change in activity level
- ☐ Excessive drug or alcohol use
- ☐ Isolation/ withdrawal
- ☐ On guard/ hypervigilant
- ☐ Agitated/ jittery/ shaky
- ☐ Violent or dangerous behavior
- ☐ Acts younger than age (children or youth)

EMOTIONAL

- ☐ Sadness, tearful
- ☐ Irritable, angry
- ☐ Anxious, fearful
- ☐ Despair, hopeless
- ☐ Feelings of guilt/ shame
- ☐ Numb, disconnected

PHYSICAL

- ☐ Headaches
- ☐ Stomach problems
- ☐ Difficulty falling or staying asleep
- ☐ Eating problems
- ☐ Worsening of health problem
- ☐ Fatigue, exhaustion

COGNITIVE

- ☐ Distressing dreams, nightmares
- ☐ Intrusive thoughts, images
- ☐ Difficulty concentrating
- ☐ Difficulty remembering things
- ☐ Difficulty making decisions
- ☐ Preoccupied with death/ destruction

☐ **COPING WELL; NONE OF THE ABOVE APPLY**

PLEASE CONTINUE ON PAGE 2 (ON BACK)

REFERRAL (select all that were communicated)

- ☐ crisis counseling program services (e.g., group counseling, team leader, follow-up)
- ☐ mental health services (e.g., professional, longer-term counseling, treatment, behavioral, or psychiatric services)
- ☐ substance abuse services (e.g., professional, behavioral, or medical treatment or self-help groups, such as AA or NA)
- ☐ community services (e.g. FEMA, loans, housing, employment, social services)
- ☐ other (specify in box)> _____

Note what the referral was for not where it was made to.

☐ **NO REFERRAL PROVIDED**

Reviewer Name _____ Signature _____ Date of Review _____

INSTRUCTIONS: INDIVIDUAL CRISIS COUNSELING SERVICES ENCOUNTER LOG

When to Use This Form:

Complete this form immediately **after** the individual crisis counseling service is provided.

1. Complete this form for each individual who receives individual crisis counseling services.
2. An individual crisis counseling encounter is defined as a contact where the discussion goes beyond education and assists persons to understand their current situation and reactions, review options, or address their emotional support or referral needs.
3. This form is also to be used for **families**. Complete a single form for each member of the family that participates in/receives crisis counseling. For example, a husband and wife along with their two children attend an individual crisis counseling session. The husband and wife actively participate with the crisis counselor, but the children sit quietly. You must complete one form for the husband and a separate form for the wife.
4. This form is not intended to be used as a survey. Do not ask the individual for any of the information on this form. Complete all items on the form based on your best observations and information you received during the encounter.

PROJECT # - FEMA disaster declaration number. Example: DR-XXXX-State
PROVIDER NAME - The name of the program/agency.
PROVIDER # - The unique number your program/agency is providing services under.
EMPLOYEE # - YOUR employee number.
DATE OF SERVICE - The date of the encounter in the format MM/DD/YYYY, e.g., 01/01/2008.
COUNTY CODE OF SERVICE - The 3 digit FIPS code for the county where the service occurred.
ZIP CODE OF SERVICE - The zip code of the location where the service occurred.

LOCATION OF SERVICE - Where did you provide the service? SELECT ONLY ONE.
VISIT TYPE - Was this encounter with one person or with two or more related individuals (family). Please complete one form for each active participant. If the encounter was with two or more unrelated individuals, use the group counseling form.
VISIT NUMBER - Based on your conversation with the individual, is this the 1st, 2nd, 3rd, 4th, 5th or more visit for this person to your program? All visits did not have to be with you. SELECT ONLY ONE.
DURATION - How long did your encounter last? SELECT ONLY ONE. If the encounter was < 15 minutes, record it on the Weekly Tally.

RISK CATEGORIES - These are factors that an individual may have experienced or may have present in their life that could increase their need for services. MORE THAN ONE CATEGORY MAY APPLY. SELECT ALL CATEGORIES THAT APPLY.

DEMOGRAPHIC INFORMATION - For each variable, SELECT ONLY ONE.
AGE - The age you perceived the person to be. SELECT ONLY ONE.
SEX - Was the person male or female? SELECT ONLY ONE.
RACE - Based on your observations and your conversation with the individual, what race do you think the individual would identify himself or herself as being? SELECT ALL THAT APPLY.
ETHNICITY - Based on your observations and your conversation with the individual, does this person self-identify as Hispanic/Latino? SELECT ONLY ONE.
PRIMARY LANGUAGE OF CONTACT - What language did you actually and primarily use to speak with this individual during the encounter? This may be different than the preferred language. If "OTHER" (not English or Spanish), fill in the other language that the person spoke in. SELECT ONLY ONE.

EVENT REACTIONS - Do not use this as a checklist during the encounter. Complete this based on your observations and conversation AFTER the service is complete. SELECT ALL THAT APPLY. If the person has no apparent problems check, "coping well."

REFERRALS - Based on your conversation with this individual, you may have referred the individual for other services. In the REFERRAL box, select all of the types of services you referred the person to. If the service is not listed, please provide the type of service next to "OTHER SERVICES."
REVIEWER - Team lead or direct supervisor to review completed form for accuracy and then sign and date (date of review).

Please submit the completed form to the designated person in your agency who will review the form.
Thank you for taking the time to complete this form accurately and completely!