|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Facilitator: |  | Phone: | | Agency: |
| SW Name: |  | SW Phone: | | SW Fax: |
| Date of Intake: |  | | | |
| Service Delivery Type: Telehealth  In-Person | | | Service delivery type has been assessed: Yes  No | |
| **DEMOGRAPHIC INFORMATION**  The client is  and self-identifies as . The client’s preferred language is .  Client states that the reason for referral to treatment is [brief description reflecting client’s understanding for referral]:      .  This case is currently . The client is the (alleged)  parent.  Client  the allegations of child physical abuse.  Client and/or client’s family have immigrated to the United States to escape war, persecution, and/or poverty  Yes  No  If “Yes”, describe how immigration history and/or cultural/identity factors may have influenced client’s understanding of the protective issues or willingness to collaborate with CFWB | | | | |

**MENTAL STATUS EXAM & ASSESSMENT RESULTS**

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| **Mental Status/Psychiatric Symptom Checklist:**  The following *current* symptoms were rated as MODERATE:  The following *current* symptoms were rated as SEVERE: |
| **Screening Tool Results** (indicate name and results of all tests administered):   |  |  | | --- | --- | | Michigan Alcohol Screening Test (MAST) | Score:       Rating: | | Drug Abuse Screening Test (DAST) | Score:       Rating: | | Other Screening Tool Administered: | Results: | | Other Screening Tool Administered: | Results: | |
| **Strengths and Barriers** (indicate client’s readiness to change, barriers to treatment, and strengths):  **Level of commitment** to attend, participate and change through the treatment program. This commitment may vary from none to a moderate level of commitment at the time of intake:      . |

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| ☐ Client is appropriate for Child Physical Abuse Group treatment  Additional suggestions to SW for adjunctive treatment while client is in **Child Physical Abuse Group** (if applicable)**:**  ☐ Client is **not** appropriate for Child Physical Abuse Group (client to be discharged)  Reason/s client is not appropriate for group at this time:   1. Actively alcoholic or drug addicted; chemical dependency treatment is to precede treatment for child abuse 2. Seriously emotionally disturbed, appropriate psychiatric and medical care is to be addressed first 3. Unable to tolerate involvement in a group (e.g., due to personality characteristics 4. Other (describe):   Recommended alternative treatment:  Additional information referring party should know, including additional clinical concerns that require adjunctive treatment: |

**DIAGNOSIS**

List the appropriate diagnoses. Record as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual.

The Primary Diagnosis should be listed first.

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| **ICD-10 Code** | **DSM-5-TR Diagnosis** |
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**GOALS TO ADDRESS IN TREATMENT**

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| * Understand definitions of Child Abuse * Understand known child abuse risk and protective factors AND apply them to their own case * Understand defense Mechanisms (Minimize, Deny and Blame) * Understand myths and beliefs regarding provocation by the child * Accept responsibility for the abuse occurring while the child was under their care * Describe and discuss above factors in relation to parent’s case * Describe strategies the parent has used for expressing or managing frustration or anger in appropriate, adaptive ways * Discuss own denial in group, reasons for the denial, and triggers for denial. * Spontaneously place responsibility for the abuse on the offender * Spontaneously express empathy in group for the child and what the child has experienced * Share in group the specific statements and behaviors parent has provided to the child that reflect support, acceptance, and validation * Identify the emotional and/or behavioral effects of child physical abuse and how to effectively and appropriately help the child manage these trauma symptoms if they appear * If applicable, acknowledge own physical abuse as a child and how that abuse affected client’s ability to parent own child * If client is offending parent, is able to describe relapse prevention strategies and behaviors parent will use to prevent future abuse of child and develop a relapse prevention plan. * If client is non-protecting parent, client is able to describe offender’s relapse prevention plan and how client will support partner’s relapse prevention plan * Learn components of safety planning: prevention and intervention * Describe own prevention and intervention plans that parent will use to keep child safe   **Additional Treatment Goals (if indicated for this client):** |

**SIGNATURE**

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| --- | --- |
| Provider Signature: | License/Registration #: |
| Print Name: | Signature Date: |
| Provider Phone Number: | Provider Fax Number: |
| ***Required for Interns Only*** | |
| Supervisor Printed Name: | License type and #: |
| Supervisor Signature: | Date: |

**Date faxed to Child and Family Well-Being SW:**