LCSWA Clinical Case Summary OUTLINE

[Type or Print CLEARLY. The case narrative is required during each six-month reporting period, but no longer to be submitted to the Board, except upon request. The case narrative is a supervisory tool and should be reviewed in supervision, signed, and maintained by the clinical supervisor.]

Case Narrative: When preparing your case narrative, consider the bulleted information under each heading and document when relevant in narrative form, using complete sentences. [Your narrative will replace the bulleted items.] Use pseudo name or initials for client name and location (i.e. JT or Client A, resides in a small community in rural North Carolina). Do NOT present in abbreviated or outline format.

➤ HISTORY:
  • Identifying and Demographic Information for client (Use initials - NO real names)
  • Social/family history
  • Prior Criminal/Legal History
  • Prior/Current Military Experience
  • Chemical Use History

➤ CLINICAL ASSESSMENT AND DIAGNOSIS:
  • Presenting Problems/Symptoms and Referral Source
  • Summary of Prior Counseling/Treatment History
  • Mental Status Exam
  • Clinical Impressions and Diagnostic Summary
  • Diagnosis as defined in 21 NCAC 63 .0102(13)

➤ TREATMENT:
  • Treatment Plan/Goals
  • Identify treatment strategies/modalities used by you, including rationale for use
  • Describe HOW you carried out treatment strategies, including how you used the therapeutic relationship to implement intervention strategies
  • Client’s response to treatment
  • Termination/transfer assessment, plan, and process