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| **Client Initial Visit Report** |
| Date: | Click or tap to enter a date. | Social Worker:  | Click or tap here to enter text. |
| Client: | Click or tap here to enter text. | Provider Agency: | Click or tap here to enter text. |
| Counselor Name: | Click or tap here to enter text. |
| Service(s) Provided: | Click or tap here to enter text. |
| Date of Attendance:  | Click or tap to enter a date. |
| Statement of Prognosis: | Click or tap here to enter text. |
| Explanation of Prognosis & Estimated Length of Treatment:  |
| Click or tap here to enter text. |
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| **Goals and Treatment Recommendations**Please list the client’s goals and explain their treatment recommendations. |
| Goal 1: | Click or tap here to enter text. |
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| Goal 2: | Click or tap here to enter text. |
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| Goal 3: | Click or tap here to enter text. |
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| Goal 4: | Click or tap here to enter text. |
|  |
| Goal 5: | Click or tap here to enter text. |
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| Treatment Recommendations:What are your overall treatment recommendations for this client? Click or tap here to enter text.Is individual therapy appropriate for this client?Click or tap here to enter text.Are there additional services you would recommend for this client?Click or tap here to enter text. |
| Click or tap here to enter text. |  | Click or tap to enter a date. |
| Therapist Name/License # |  | Date. |
| ***NOTE: THIS REPORT SHOULD BE SENT TO THE HHSA CWS CLERICAL DEPT. AT THE FOLLOWING EMAIL ADDRESS:*** ***CPS.CLERICAL@EDCGOV.US******. DO NOT SEND THE REPORT TO THE HHSA FISCAL DEPT.****\* Phone: (530) 642-7100 \* Fax (530) 626-7427 \** |