

Clinical Summary Form
Professional Assistance of Central Texas

Section I - Client Information

Quarter: _____

Relation to Employee: Self Spouse Dependent

Last Name: _____ First Name: _____ MI: _____

Sex: _____ Age: _____ Date of Birth: ___/___/___ SS# _____ - _____ - _____

Address: _____

City: _____ State & Zip: _____

Telephone: (Home) _____ (Work) _____

Occupation: _____ W. Co. Dept: _____

Insurance: UBH Other

Section II - Employee Information: If client is not also the employee

Last Name: _____ First Name: _____ MI: _____

Sex: _____ Age: _____ Date of Birth: ___/___/___ SS# _____ - _____ - _____

Address: _____

City: _____ State & Zip: _____

Telephone: (Home) _____ (Work) _____

Occupation: _____ W. Co. Dept: _____

Insurance: UBH Other

Section III - Clinical Information

Type of Referral: Self-referral Management Suggested Management Required

Treatment Focus: (Please check all that apply)

- | | |
|---|--|
| <input type="radio"/> Chemical Dependency/Abuse | <input type="radio"/> Mental Health/Illness |
| <input type="radio"/> Family Issues/Conflict | <input type="radio"/> Marital/Couples Conflict |
| <input type="radio"/> Occupational | <input type="radio"/> Critical Incident |
| <input type="radio"/> Other (specify) _____ | |

Total Sessions Used: _____

Case Status: (please circle one) Completed Ongoing Referred

Additional Resources Referred to:

Clinician: _____ Date: _____