University of Colorado Colorado Springs

HealthCircle Aging Center
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Caregiver Intake Report (Clinician)

Date of Examination: Date of Report:
Referred by:

Caregiver Identifying Information	Care Recipient Identifying Information
Name:	Name:
DOB:	DOB:
Place of Birth:	Place of Birth:
Race/Ethnic Background:	Race/Ethnic Background:
Partner Status:	Partner Status:
Education:	Education:
Occupation/Employment Status:	Occupation/Employment Status:
Living Situation:	Living Situation:
Religion/Spirituality:	Religion/Spirituality:

IDENTIFIED PROBLEMS

Please answer the following questions in narrative form: What are they? How long have they been going on (Onset date and progression)? How often are they encountered?
Do other family members share the view of the problem(s)? If No, explain
What has been done to address the problem(s)? With what results?

Caregiver Medical Information	Care Recipient Medical Information
PCP:	PCP:
Other health care providers:	Other health care providers:
Medical Dx:	Medical Dx:
Rx Meds/Doses:	Rx Meds/Doses:
OTC:	OTC:
Smoke: Yes No	Smoke: Yes No
Alcohol: Yes No	Alcohol: Yes No
Other Substances:	Other Substances:
Major Accidents:	Major Accidents:
Surgeries:	Surgeries:
Disabilities:	Disabilities:

Specific Problems for the Caregiver: Please answer the following questions in narrative form: In what ways has the situation the client is in affected their everyday life (sleep, appetite, interests, intimacy, social life, finances)?

FAMILY HISTORY

Please include the following information, including relevant details, in this section: describe family of origin/choice; current relationships with parents, siblings, partner, children; any significant losses within the past year for the caregiver and the care recipient; for both CG & CR is there any history of mental illness/suicide, psychological and/or psychiatric treatments, neurological illness, any previous neuropsychological assessments, drug or alcohol problems, physical/emotional/sexual abuse, legal problems; who are involved in the decision making about the care recipient and in what capacity? are there any other family members not involved in the decision making process and why are they not involved? who/what is in the CG's support system; CG's self-care routine; what the CG wants to accomplish in therapy.

CLINICAL FORMULATION:

Besides your case conceptualization, include which stage of care the CG is in (i.e., pre-cg, early, middle, late, or post cg structure) & what is occurring that makes you believe this. Be sure to speak to which problem(s) are of focus for the CG (e.g., naming the problem, role re-structuring, etc.) and why is this a problem now.

Concerns for CG:

Concerns for CR:

Diagnostic Impressions:

Axis I (include V codes):
Axis II (if sx do not meet criteria, include features):
Axis III
Axis IV
Axis V

RECOMMENDATIONS:

A. Recommendations for referrals (circle those that apply):

AAA, Pharmacological Consult, Physician Consult, Neuropsychological Testing Senior Center Home Health Care Respite/Adult Day Care Placement Referrals (Assisted/Nursing) Attorney/Legal
Other_____

B. Recommendations for treatment modality (circle those that apply):

Individual Therapy, Family Therapy, Couples Therapy, Group Therapy, CG Classes

C. Treatment goals and strategies:

1.
2.
3.

_____ _____

Psychology Trainee /Date Supervisor/Date