PROJECT #

OMB NO 0930-0270
Expiration Date xx/xx/xxxx

Individual/Family Crisis Counseling Services Encounter Log

Provider Name ☐ Provider Number ☐

Date of Service (mm/dd/yyyy) ☐ County of Service ☐

1st Employee # ☐ 2nd Employee # ☐ e of Service ☐

VISIT TYPE (please check the appropriate box)

Number of participants in this encounter (either Individual OR Family or Household)

Individual = 1 ☐

Family or Household (2 or more individuals) = 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more ☐

VISIT NUMBER ☐ First visit ☐ Second visit ☐ Third visit ☐ Fourth visit ☐ Fifth visit or later

DURATION ☐ 15–29 minutes ☐ 30–44 minutes ☐ 45–59 minutes ☐ 60 minutes or more

DEMOGRAPHIC INFORMATION

Number of MALES per age category in this encounter (indicate # in box)

☐ preschool (0–5 years) ☐ child (6–11 years) ☐ adolescent (12–17 years) ☐ adult (18–39 years) ☐ adult (40–64 years) ☐ older adult (65 years or older)

Number of FEMALES per age category in this encounter (indicate # in box)

☐ preschool (0–5 years) ☐ child (6–11 years) ☐ adolescent (12–17 years) ☐ adult (18–39 years) ☐ adult (40–64 years) ☐ older adult (65 years or older)

Ethnicity (for individual encounter, select only one; for family encounter, select all that apply)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race of participant(s) in this encounter (select all that apply)

☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian/Pacific Islander ☐ White

Primary language spoken during encounter (select one)

☐ English ☐ Spanish ☐ Other (specify in box) >>>> ☐

If any of the participants has a disability, or other access or functional need, indicate the type (select all that apply).

- [ ] Physical (mobility, visual, hearing, medical, etc.)
- [ ] Intellectual/Cognitive (learning disability, mental retardation, etc.)
- [ ] Mental Health/Substance Abuse (psychiatric, substance dependence, etc.)

LOCATION OF SERVICE (select one)

- ☐ school or child care (all ages through college)
- ☐ community center (e.g., recreation club)
- ☐ provider site/mental health agency (agency involved with Crisis Counseling Assistance and Training Program [CCP])
- ☐ workplace (workplace of the disaster survivor and/or first responder)
- ☐ disaster recovery center (e.g., Federal Emergency Management Agency [FEMA], American Red Cross)
- ☐ place of worship (e.g., church, synagogue, mosque)
- ☐ retail (e.g., restaurant, mall, shopping center, store)
- ☐ public place/event (e.g., street, sidewalk, town square, fair, festival, sports)
- ☐ temporary home (including friend or family homes, group homes, shelters, apartments, trailers, and other dwellings)
  - ☐ IF HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN < AGE 18 LIVE IN THIS HOME.
- ☐ permanent home
  - ☐ IF HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN < AGE 18 LIVE IN THIS HOME.
- ☐ phone counseling (15 minutes or longer)
  - ☐ If HOTLINE, HELPLINE, or CRISIS LINE, please **check here.**
- ☐ medical center (e.g., doctor, dentist, hospital, mental health or substance abuse specialty center)
- ☐ other (specify in box)> ____________

RISK CATEGORIES (select all that apply)

- ☐ family missing/dead
- ☐ friend missing/dead
- ☐ pet missing/dead
- ☐ home damage
- ☐ vehicle or major property loss
- ☐ other financial loss
- ☐ disaster unemployed (self or household member)
- ☐ life was threatened (self or household member)
- ☐ witnessed death/injury (self or household member)
- ☐ assisted with rescue/recovery (self or household member)
- ☐ injured or physically harmed (self or household member)
- ☐ had to change schools (for children or youth)
- ☐ evacuated quickly with no time to prepare
- ☐ prolonged separation from family
- ☐ displaced from home 1 week or more
- ☐ sheltered in place or sought shelter due to immediate threat of danger
- ☐ past substance use/mental health problem
- ☐ preexisting physical disability
- ☐ past trauma

EVENT REACTIONS (select all that apply)

Please indicate the total # of participants experiencing event reactions. ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more

	BEHAVIORAL		EMOTIONAL		PHYSICAL		COGNITIVE
☐	extreme change in activity level	☐	sadness, tearful	☐	headaches	☐	distressing dreams, nightmares
☐	excessive drug or alcohol use	☐	irritable, angry	☐	stomach problems	☐	intrusive thoughts, images
☐	isolation/withdrawal	☐	anxious, fearful	☐	difficulty falling or staying asleep	☐	difficulty concentrating
☐	on guard/hypervigilant	☐	despair, hopeless	☐	eating problems	☐	difficulty remembering things
☐	agitated/jittery/shaky	☐	feelings of guilt/shame	☐	worsening of health problems	☐	difficulty making decisions
☐	violent or dangerous behavior	☐	numb, disconnected	☐	fatigue, exhaustion	☐	preoccupied with death/destruction
☐	acts younger than age (children or youth)						

☐ **COPING WELL: NONE OF THE ABOVE APPLY**

(If there are no participants experiencing the above event reactions, please check this box.)

FOCUS OF ENCOUNTER (select all that apply)

INFORMATION/EDUCATION ABOUT:	TIPS FOR:	HEALTHY CONNECTIONS	
☐ reactions to disaster	☐ reducing negative thoughts	☐ building social network(s)	other (specify in box) ☐
☐ community resources	☐ managing physical and emotional reactions (e.g., breathing techniques)	☐ participating in community action	
☐ this crisis counseling program	☐ doing positive things		
	☐ problem solving		

MATERIALS PROVIDED FOR THIS ENCOUNTER

Were flyers, brochures, handouts, or other materials provided to this/these participant(s)? ☐ YES ☐ NO

REFERRAL (select all that were communicated)

☐ crisis counseling program services (e.g., group counseling, referral to team leader, followup visit)

☐ mental health services (e.g., professional, longer-term counseling, treatment, behavioral, or psychiatric services)

☐ substance abuse services (e.g., professional, behavioral, or medical treatment or self-help groups, such as Alcoholics Anonymous or Narcotics Anonymous)

☐ community services (e.g., FEMA, loans, housing, employment, social services)

☐ resources for those with disabilities, or other access or functional needs

☐ other (specify in box) ☐

☐ **NO REFERRAL PROVIDED**

Reviewer Name ☐ Signature ☐ Date of Review ☐

INSTRUCTIONS:
INDIVIDUAL/FAMILY CRISIS COUNSELING SERVICES ENCOUNTER LOG

When to Use This Form:
Complete this form immediately **after** the individual or family/household crisis counseling service is provided.

1. Complete this form for each individual or family/household that receives crisis counseling services of 15 minutes or more.
2. An individual or family/household crisis counseling encounter is defined as a contact where the discussion goes beyond education and assists understanding of current situations and reactions, involves review of options, or addresses emotional support or referral needs.
3. This form is not intended to be used as a survey. Do not ask the individual for any of the information on this form. Complete all items on the form based on your best observations and information you received during the encounter.

PROJECT #—FEMA disaster declaration number, e.g., DR-XXXX-State.
PROVIDER NAME—The name of the program/agency.
PROVIDER NUMBER—The unique number under which your program/agency is providing services.
DATE OF SERVICE—The date of the encounter in the format mm/dd/yyyy, e.g., 01/01/2012.
COUNTY OF SERVICE—The county where the service occurred.
1st EMPLOYEE #—YOUR employee number (must be numeric and no more than 6 digits.)
2nd EMPLOYEE #—Employee number of your teammate during this encounter (must be numeric and no more than 6 digits.)
ZIP CODE OF SERVICE—The zip code of the location where the service occurred.

VISIT TYPE—Was this encounter with one person (individual) or with two or more individuals living as a family or household (family or household)?

VISIT NUMBER—Based on your conversation, is this the first, second, third, fourth, fifth, or later visit for this person, family, or household to your program? All visits did not have to be with you. SELECT ONLY ONE.

DURATION—How long did your encounter last? SELECT ONLY ONE. If the encounter was under 15 minutes, record it on the Weekly Tally Sheet.

DEMOGRAPHIC INFORMATION—For each variable.

NUMBER OF MALES IN THIS ENCOUNTER—Please indicate the number of males for each age category that participated in this encounter. (You should record numbers into the boxes instead of checkmarks.)

NUMBER OF FEMALES IN THIS ENCOUNTER—Please indicate the number of females for each age category that participated in this encounter. (You should record numbers into the boxes instead of checkmarks.)

ETHNICITY—Based on your observations and your conversation, do any of the participants self-identify as Hispanic/Latino?

RACE—Based on your observations and your conversation with the participants, what race do you think participant(s) would identify as being? SELECT ALL THAT APPLY. If participant(s) are of more than one race, you should indicate all races that you believe to be represented. For a family encounter, if more than one race is represented, you should indicate all races that you believe to be represented.

PRIMARY LANGUAGE SPOKEN DURING ENCOUNTER(S)—Which language did you actually and primarily use to speak with this individual during the encounter? This may be different than the preferred language. If "OTHER" (not English or Spanish, may include sign language), fill in the other language that the person used. (SELECT ONLY ONE.)

PERSONS WITH DISABILITIES OR OTHER ACCESS OR FUNCTIONAL NEED(S)—Based on your observations and your conversation with the participants, does anyone have a physical, intellectual/cognitive, or mental health/substance abuse disability? SELECT ALL THAT APPLY.

- Physical: includes disorders that impair mobility, seeing, hearing, as well as medical conditions, such as diabetes, lupus, Parkinson's, AIDS, or multiple sclerosis (MS).
- Intellectual/Cognitive: includes learning disabilities, birth defects, neurological disorders, developmental disabilities, or traumatic brain injuries (e.g., Down syndrome, mental retardation).
- Mental Health/Substance Abuse: includes psychiatric disorders, such as bipolar disorder, depression, posttraumatic stress disorder (PTSD), schizophrenia, and substance dependence.

LOCATION OF SERVICE—Where did this encounter take place? SELECT ONLY ONE.

RISK CATEGORIES—These are factors that participants may have experienced or may have present in their lives that could increase their need for services. MORE THAN ONE CATEGORY MAY APPLY. SELECT ALL CATEGORIES THAT APPLY.

EVENT REACTIONS—Do not use this as a checklist during the encounter. Complete this based on your observations and the conversation AFTER the service is complete. SELECT ALL THAT APPLY. If the participants have no observable or reported problems, check "coping well: none of the above apply."

FOCUS OF INDIVIDUAL, FAMILY, OR HOUSEHOLD ENCOUNTER—What is the focus of the encounter? SELECT ALL THAT APPLY. If the focus is different from the categories listed, please select "OTHER," and fill in the blank with the primary purpose.

MATERIALS PROVIDED IN THIS ENCOUNTER—Did you leave any materials with the participant, family, or household? This refers to printed materials such as a brochure, flyers, tip sheets, or other printed information. SELECT ONLY ONE.

REFERRAL—Based on your conversations, you may have referred the participants for other services. In the REFERRAL box, select all of the types of services to which you referred participants. If you made a referral to a service not listed, please check the box labeled "other" and write in the specific type of referral.

REVIEWER—Team lead or direct supervisor to review completed form for accuracy and then sign and date (date of review).

Please submit the completed form to the designated person in your agency who will review the form.

Thank you for taking the time to complete this form accurately and fully!

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0930-xxxx. Public reporting burden for this collection of information is estimated to average 8 minutes per encounter, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, MD 20857.