Project # _____

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

Individual/Family Crisis Counseling Services Encounter Log

Provider Name _____ Provider # _____

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

1st Employee # _____ 2nd Employee # _____ ZIP Code 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)

Number of TRANSGENDER individuals 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)

Race/ethnicity of participants in this encounter (select all that apply)

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

☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Hispanic or Latino

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, developmental delay, etc.) ☐ Mental Health/Substance Abuse (psychiatric, substance dependence, etc.)

LOCATION OF SERVICE (select one)

☐ school and 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 damaged or destroyed
- ☐ vehicle or major property loss
- ☐ other financial loss
- ☐ disaster unemployed (self or household member)
- ☐ injured or physically harmed (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)
- ☐ had to change schools
- ☐ prolonged separation from family
- ☐ evacuated quickly with no time to prepare
- ☐ 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

- ☐ extreme change in activity level
- ☐ excessive drug or alcohol use
- ☐ isolation/withdrawal
- ☐ on guard/hypervigilant
- ☐ agitated/jittery/shaky
- ☐ violent or dangerous behavior
- ☐ acts younger than age (children or youth)

EMOTIONAL

- ☐ sadness, tearful
- ☐ irritable, angry
- ☐ anxious, fearful
- ☐ despair, hopeless
- ☐ feelings of guilt/shame
- ☐ numb, disconnected

PHYSICAL

- ☐ headaches
- ☐ stomach problems
- ☐ difficulty falling or staying asleep
- ☐ eating problems
- ☐ worsening of health problems
- ☐ fatique, exhaustion

COGNITIVE

- ☐ distressing dreams, nightmares
- ☐ intrusive thoughts, images
- ☐ difficulty concentrating
- ☐ difficulty remembering things
- ☐ difficutly making decisions
- ☐ preoccupied with death/destruction

☐ **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: ☐ reactions to disaster ☐ community resources ☐ this crisis counseling program

TIPS FOR:

☐ reducting negative thoughts ☐ managing physical and emotional reactions (e.g., breathing techniques) ☐ doing positive things ☐ problem solving

HEALTHY CONNECTIONS: ☐ mutual support/building social networks ☐ participating in community action

☐ other (specify in box) _____

FOCUS OF GROUP SESSION (select all that apply)

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, referall to team leader, follow-up 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 understand 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-XXX-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/yyy, 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 lond did your encounter last? SELECT ONLY ONE. If the encounter was under 15 minutes, use 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.)

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

RACE/ETHNICITY—Based on your observations and your conversation with the participants, what race/ethnicity do you think the participant(s) would identify as being? SELECT ALL THAT APPLY. If participant(s) are of more than one race/ethnicity, you should indicate all race/ethnicities that you believe to be represented. For a family encounter, if more than one race/ethnicity is represented, you should indicate all races/ethnicities 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, or hearing, as well as medical conditions, such as diabetes, lupus, Parkinson’s, AIDS, or multiple sclerosis (MS).
- Intellectual/Cognitive: includes a learning disability, birth defects, neurological disorders, developmental disabilites, or traumatic brain injuries, (e.g., Down syndrome).
- 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 the encounter occur? SELECT ONLY ONE.

RISK CATEGORIES—These are the factos 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 coversation 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 fillin 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!