DELAWARE HEALTH & SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
COUNSELING APPOINTMENT INFORMATION RECORD

Name: ___________________________ MCI #: ___________________ Date: ______________

Is this an (check one): Initial Appointment __________ or Return Visit __________

1. Presenting problem:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

2. Current findings:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

3. Proposed Treatment Plan (length, frequency and number of visits requested): Initials
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Next Appointment: _______________ Therapist Signature & Title