Termination Checklist

Client Name: **Date:**

CLIENT INFORMATION

Full Name

Date of Birth

Gender

Contact Information

Emergency Contact

PRESENTING ISSUES

Primary Complaint

Duration of Symptoms

Severity of Symptoms

Impact on Daily Life

MEDICAL HISTORY

Current Medications

Allergies

Past Medical History

Family Medical History

SUBSTANCE USE HISTORY

Types of Substances Used

Frequency and Quantity

Duration of Use

Previous Treatment for Substance Use

Termination Checklist Continued

MENTAL HEALTH HISTORY

Previous Mental Health Diagnoses ○

History of Therapy or Counseling ○

Current Mental Health Symptoms

SOCIAL HISTORY

Living Situation ○

Employment Status ○

Support System

Legal Issues ○

RISK ASSESSMENT

□ Suicidal Ideation

□ Homicidal Ideation ○

□ Self-Harm Behavior ○

□ Risk to Others

ASSESSMENT TOOLS

Additional Assessment Tool Completed _____

Additional Assessment Tool Completed _____

Additional Assessment Tool Completed _____

Client Signature: _____

Clinician Signature: _____