OUTWARD BOUND

RETURN

COUNSELING QUESTIONNAIRE

Applicant Name:_____ **Course Number:**_____

Dear Health Care Provider,

Your client is being screened by Outward Bound for participation in one of our programs. The applicant indicated that counseling has been provided by you within the past two years and has given us permission to contact you. We respectfully request your input as we determine if Outward Bound is appropriate for your client at this time.

Outward Bound is physically challenging, but it is an intense emotional and interpersonal experience as well. Participants are asked to do things they may not believe they are capable of doing. Screening is designed to determine if our program (a) will meet the needs of the individual while supporting individual and group safety and (b) is within the scope of their capabilities.

The classroom may be a wilderness setting. The group consists of two instructors and 6-12 participants, often from diverse backgrounds. Activities may include canoeing, kayaking, backpacking, winter camping, rock climbing, challenge course, community service project and solo*. Skills are taught from a beginner level, and expeditions are conducted in various weather conditions in different environments: ocean, river, mountain, forest, and urban areas. The terrain may be steep, muddy, rocky, heavily wooded, swampy and/or buggy.

The focus of Outward Bound is experiential education. Our goal is to assist each participant to recognize and reach beyond self-imposed limits and to facilitate the group as they move from dependence to independence and cooperation.

There are wonderful "highs" with Outward Bound but, due to the setting, participants may be cold, wet, tired, hungry and hot at times. They may confront personal fears such as heights, water, being alone, and interacting with or trusting others. The personal interaction and stress may create frustration and possible anger as participants deal with others within the group who may be experiencing similar emotions. There will be opportunities for processing events through informal group discussions, but we do not endeavor to control the outcome in any prescribed fashion. As stress is experienced, the potential exists that a student may perceive failure or peer rejection. **While our staff are well-qualified wilderness instructors, they are not psychotherapists.**

Your assistance in helping us determine if this individual is capable of having a safe and positive Outward Bound experience is invaluable and greatly appreciated. Complete this questionnaire and return it within one week of receipt, **as final acceptance to the program is contingent upon the information contained within this form.**

Thank you!

***Solo is 6-72 hours in duration and offers time for introspection, quiet, rest and journal writing. Students camp alone and are given specific boundaries, a tent/tarp, sleeping bag, water supply and a small amount of food. They are checked daily by instructors and have a means of communicating distress if the need arises.**

RETURN

DIAGNOSIS

Please indicate your client's diagnosis(es):

- ❑ ADHD
- ❑ Autism Spectrum Disorder
- ❑ Anxiety Disorder
- ❑ Bipolar Disorders
- ❑ Depressive Disorder
- ❑ Disruptive and Conduct Disorder
- ❑ Eating Disorder
- ❑ Intellectual Disability
- ❑ Learning Disability
- ❑ Obsessive-Compulsive Disorder
- ❑ Personality Disorder
- ❑ Schizophrenia Spectrum Disorder
- ❑ Substance Related Disorder
  (Note: Please indicate substance(s) and level of problem; use/abuse/dependence, in NOTES section below)
- ❑ Trauma and Stressor Related Disorder
- ❑ Other: _____

Indicate the recency of each diagnosis. Recency: How recent were major symptoms?

DIAGNOSIS _____	DIAGNOSIS _____
❑ < 3 months	❑ < 3 months
❑ 3-6 months	❑ 3-6 months
❑ 6-12 months	❑ 6-12 months
❑ > 1 year	❑ > 1 year

Indicate the DURATION of each diagnosis. DURATION: How long has the individual had this condition?

DIAGNOSIS _____	DIAGNOSIS _____
❑ < 3 months	❑ < 3 months
❑ 3-6 months	❑ 3-6 months
❑ 6-12 months	❑ 6-12 months
❑ > 1 year	❑ > 1 year

NOTES

TREATMENT/THERAPY

Indicate below any treatment(s) or therapy that apply(ies) to your client **CURRENTLY** or within the past **YEAR**.

TYPE OF TREATMENT/THERAPY:

- ❑ Medication(s)
- ❑ Outpatient Counseling
- ❑ Day Treatment
- ❑ Residential Treatment
- ❑ Hospitalization
- ❑ Special Treatment (e.g. ECT)
- ❑ Other (Specify)

How long has it been since the last treatment and/or therapy?

Treatment Type: _____

❑ Current ❑ < 3 months ❑ 3-6 months
❑ 6-12 months ❑ > 1 year

Treatment Type: _____

❑ Current ❑ < 3 months ❑ 3-6 months
❑ 6-12 months ❑ > 1 year

Treatment Type: _____

❑ Current ❑ < 3 months ❑ 3-6 months
❑ 6-12 months ❑ > 1 year

MEDICATION STABILITY

1. _____	2. _____
❑ < 1 month	❑ < 1 month
❑ < 3 months	❑ < 3 months
❑ 3-6 months	❑ 3-6 months
❑ 6-12 months	❑ 6-12 months
❑ > 1 year	❑ > 1 year

3. _____	4. _____
❑ < 1 month	❑ < 1 month
❑ < 3 months	❑ < 3 months
❑ 3-6 months	❑ 3-6 months
❑ 6-12 months	❑ 6-12 months
❑ > 1 year	❑ > 1 year

RETURN

SYMPTOMS (OBSERVED/REPORTED)

Indicate the symptoms that your client has manifested within the past **SIX MONTHS**, only.

LIST I

- ❑ Annoying
- ❑ Argumentative
- ❑ Avoidance (e.g, people, places, activities)
- ❑ Binge Eating
- ❑ Blames Others
- ❑ Controlling
- ❑ Deceitful
- ❑ Defiance
- ❑ Difficulty Concentrating
- ❑ Difficulty Organizing
- ❑ Diminished Appetite
- ❑ Disturbed Body Perception
- ❑ Easily Distracted
- ❑ Excessive Exercise
- ❑ Fasting
- ❑ Fatigue
- ❑ Feelings of Guilt or Worthlessness
- ❑ Flight of Ideas
- ❑ Hyperactive
- ❑ Hyper-Vigilance
- ❑ Immature for Age
- ❑ Inattentive
- ❑ Insomnia
- ❑ Interrupts
- ❑ Irritability
- ❑ Labile
- ❑ Lack of Empathy
- ❑ Little or No Motivation
- ❑ Loss of Temper
- ❑ Low Self-Esteem
- ❑ Memory Loss
- ❑ Motor Restless
- ❑ Oppositional
- ❑ Perfectionism
- ❑ Poor Social Skills
- ❑ Restricted Affect
- ❑ Sadness
- ❑ Social/Occupational Dysfunction
- ❑ Suspiciousness
- ❑ Talks Excessively
- ❑ Tics
- ❑ Unable to Follow Instructions
- ❑ Use of Laxatives, Diuretics, Appetite Suppressants
- ❑ Worry

LIST 2

- ❑ Accident Prone
- ❑ Aggression
- ❑ Anxiety
- ❑ Body Weight < 85% of Normal
- ❑ Depression
- ❑ Destruction of Property
- ❑ Detachment
- ❑ Disorganized Speech
- ❑ Impaired Communication

  (e.g., delay/lack of spoken language, repetitive or idiosyncratic language)
- ❑ Impaired Social Interaction
- ❑ (e.g., no eye-contact, blank facial expression)
- ❑ Impulsivity
- ❑ Inflated Self-Esteem or Grandiosity
- ❑ Irrational Fears (death, loss of control)
- ❑ Low Frustration Tolerance
- ❑ Mania
- ❑ Perceptual or Cognitive Distortion
- ❑ Promiscuity
- ❑ Purging
- ❑ Repetitive Behavior (hand washing, counting)
- ❑ Repetitive/Stereotypical Behaviors

  (e.g., inflexible non-functional routines or rituals, stereotype/repetitive motor mannerisms)
- ❑ Restrictive Eating
- ❑ Serious Violation of Rules (truancy, run-away)
- ❑ Significant Weight Change
- ❑ Somatic Complaints
- ❑ Theft

LIST 3

- ❑ Catatonic or Disorganized Behavior
- ❑ Delusions
- ❑ Dissociation
- ❑ Feeling Event is Recurring
- ❑ Flashbacks
- ❑ Hallucinations
- ❑ Mood Swings
- ❑ Recurrent, Persistent Intrusive Thoughts
- ❑ Self-Harm
- ❑ Thoughts of Death
- ❑ Use of Weapons
- ❑ Violence

OTHER

RETURN

ADDITIONAL INFORMATION

Please list your clients greatest strengths as they relate to the Outward Bound experience.

Please identify any coping skills your client utilizes.

Please give us a sense of how your client approaches self-care and asking for support.

Please share with us any tips you have for helping this client to be successful during an Outward Bound experience.

Please provide any additional information you feel should be considered while screening your client or any recommendations for our staff while working with your client.

Do you recommend that your client attends Outward Bound at this time? Yes or No. If you answered "No", please explain.

RETURN

WHODAS 2.0 SCORE

Cognition _____ Self-care _____ Life activities _____

Mobility _____ Getting along _____ Participation _____

WHODAS 2.0 Summary Score _____

GAF Score (if preferred) _____

SIGNIFICANT LIFE EVENTS

Indicate any of the following that your client has experienced within the **past six months.**

Health
- ❑ Serious Accident/Injury
- ❑ Serious Illness

Occupational
- ❑ Job Difficulty
- ❑ Job Loss

Personal
- ❑ Bankruptcy
- ❑ Frequent Moves
- ❑ Fire/Natural Disaster
- ❑ Neglect
- ❑ Sexual Abuse

Interpersonal/Family
- ❑ Adoption
- ❑ Foster Care Placement
- ❑ Relationship Loss
- ❑ Separation
- ❑ Divorce
- ❑ Death

Legal
- ❑ Legal Problems
- ❑ Probation
- ❑ Incarceration

School
- ❑ School Problems
- ❑ Academic Failure
- ❑ Suspension/Expulsion

CLIENT INFORMATION

Is this client currently in counseling with you? ❑ Yes ❑ No Date of the last session?

If "Yes", what is the frequency of sessions? _____

If "No", why was therapy terminated? _____

To your knowledge, does the client want to attend Outward Bound, or is he/she being strongly encouraged by someone else? _____

THERAPIST INFORMATION

Company Name _____ Therapist Name: _____

Therapist Signature: _____ Date _____

Discipline: _____

Telephone Number: _____ Email _____

May we contact you with questions? ❑ Yes ❑ No

If "Yes", what is the preferred method of Contact? _____

Statement of Confidentiality: All information provided to Outward Bound will remain confidential and not be released to any outside organization or agency without a written release from your client if 18+ or a parent or guardian if under 18.