

TERMINATION REPORT – B

PROBLEM CATEGORIES Check only one as primary	SUB-CATEGORIES	GOAL ATTAINMENT & RESOLUTION AT CLOSURE (Primary only)
CHILD CARE 1. Primary Assessed 2. Secondary Assessed	<input type="checkbox"/> Daycare centre <input type="checkbox"/> Home care <input type="checkbox"/> Nanny <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> Partly <input type="checkbox"/> No
FAMILY 1. Primary Assessed 2. Secondary Assessed	<input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Adult child of alcoholics <input type="checkbox"/> Adult children <input type="checkbox"/> Conflicting parenting styles <input type="checkbox"/> Blended family issues <input type="checkbox"/> Child 0-12 yrs academic <input type="checkbox"/> Child 0-12 yrs behaviour <input type="checkbox"/> Child 0-12 yrs conflict parents <input type="checkbox"/> Child 0-12 yrs social skills <input type="checkbox"/> Child 13-21 yrs academic <input type="checkbox"/> Child 13-21 yrs alcohol <input type="checkbox"/> Child 13-21 yrs behaviour <input type="checkbox"/> Child 13-21 yrs conflict law <input type="checkbox"/> Child 13-21 yrs confl. parents <input type="checkbox"/> Child 13-21 yrs depression <input type="checkbox"/> Child 13-21 yrs drugs <input type="checkbox"/> Child 13-21 yrs social skills <input type="checkbox"/> Child 13-21 yrs suicidal <input type="checkbox"/> Custody & support issues <input type="checkbox"/> Discipline of children <input type="checkbox"/> Effects of relocation on fam. <input type="checkbox"/> Effects of separation <input type="checkbox"/> Family member suicidal <input type="checkbox"/> Family of origin issues <input type="checkbox"/> Illness of children <input type="checkbox"/> Money (financial problems) <input type="checkbox"/> Parenting skills <input type="checkbox"/> Single parent <input type="checkbox"/> Violence <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> Partly <input type="checkbox"/> No
GAMBLING 1. Primary Assessed 2. Secondary Assessed	<input type="checkbox"/> Bingo <input type="checkbox"/> Casinos <input type="checkbox"/> Horse race betting <input type="checkbox"/> Lotteries <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> Partly <input type="checkbox"/> No
HEALTH 1. Primary Assessed 2. Secondary Assessed	<input type="checkbox"/> Aging <input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug addiction <input type="checkbox"/> Eating disorders <input type="checkbox"/> Insomnia <input type="checkbox"/> Medical problems/ illness <input type="checkbox"/> Physical handicap <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> Partly <input type="checkbox"/> No
INDIVIDUAL 1. Primary Assessed 2. Secondary Assessed	<input type="checkbox"/> Anger management <input type="checkbox"/> Anxiety <input type="checkbox"/> Childhood abuse <input type="checkbox"/> Childhood sexual abuse <input type="checkbox"/> Dependencies <input type="checkbox"/> Depression <input type="checkbox"/> Empty nest syndrome <input type="checkbox"/> Family of origin issues <input type="checkbox"/> Grief/ bereavement <input type="checkbox"/> Isolation <input type="checkbox"/> Low self confidence/ image <input type="checkbox"/> Menopause <input type="checkbox"/> Minor psychiatric disorder <input type="checkbox"/> Money (financial problems) <input type="checkbox"/> Mood swings <input type="checkbox"/> Motor vehicle accident <input type="checkbox"/> Panic attacks <input type="checkbox"/> Phobias <input type="checkbox"/> Severe psychiatric disorder <input type="checkbox"/> Sexuality <input type="checkbox"/> Stress management <input type="checkbox"/> Suicide <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> Partly <input type="checkbox"/> No

LEGAL 1. Primary Assessed 2. Secondary Assessed	<input type="checkbox"/> Alimony <input type="checkbox"/> Custody <input type="checkbox"/> Divorce <input type="checkbox"/> Employment <input type="checkbox"/> Harassment <input type="checkbox"/> Immigration <input type="checkbox"/> Last will/ succession	<input type="checkbox"/> Law line <input type="checkbox"/> Lawsuit <input type="checkbox"/> Legal booklet sent <input type="checkbox"/> Legal reference <input type="checkbox"/> Restraining order <input type="checkbox"/> Youth protection <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> Partly <input type="checkbox"/> No
MARITAL 1. Primary Assessed 2. Secondary Assessed	<input type="checkbox"/> Affair self <input type="checkbox"/> Affair spouse <input type="checkbox"/> Alcohol/ drugs spouse <input type="checkbox"/> Communication <input type="checkbox"/> Divorce <input type="checkbox"/> Drifting apart <input type="checkbox"/> Grief <input type="checkbox"/> Ill spouse (i.e. cancer, MS) <input type="checkbox"/> Infertility	<input type="checkbox"/> Marital difficulties <input type="checkbox"/> Money (financial problems) <input type="checkbox"/> Reconciliation <input type="checkbox"/> Separation <input type="checkbox"/> Sexuality <input type="checkbox"/> Spouse is depressed <input type="checkbox"/> Stress spouse <input type="checkbox"/> Verbal abuse <input type="checkbox"/> Violence <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> Partly <input type="checkbox"/> No
SUBSTANCE ABUSE 1. Primary Assessed 2. Secondary Assessed	<input type="checkbox"/> Drugs not specific) <input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine <input type="checkbox"/> Hashish <input type="checkbox"/> Heroin	<input type="checkbox"/> LSD <input type="checkbox"/> Marijuana <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> Partly <input type="checkbox"/> No
WORK RELATED 1. Primary Assessed 2. Secondary Assessed	<input type="checkbox"/> Absenteeism/ tardiness <input type="checkbox"/> Conflict <input type="checkbox"/> Career/ future concerns <input type="checkbox"/> Discrimination <input type="checkbox"/> Environmental concerns <input type="checkbox"/> Harassment <input type="checkbox"/> Job loss <input type="checkbox"/> Management effectiveness <input type="checkbox"/> Performance	<input type="checkbox"/> Quality/ quantity of work <input type="checkbox"/> Retirement <input type="checkbox"/> Stress/ burnout <input type="checkbox"/> Safety problems <input type="checkbox"/> Trauma/ post trauma <input type="checkbox"/> Violence <input type="checkbox"/> Work load <input type="checkbox"/> Working with others <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> Partly <input type="checkbox"/> No
OTHER 1. Primary Assessed 2. Secondary Assessed	<input type="checkbox"/> Eldercare <input type="checkbox"/> Financial <input type="checkbox"/> Rehab <input type="checkbox"/> Trauma	<input type="checkbox"/> Cultural adjustment <input type="checkbox"/> Cultural isolation <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> Partly <input type="checkbox"/> No

Counsellor's signature _____ **Date** _____