Manual for case documentations

Name, title, date.

Case documentation on the basis of the five-stage model

1. Initial situation:
- what was the reason for consultation?
- which are the expectations (explicit, implicit) of the client and of involved others?
- how is the initial therapeutic contact?

2. History, anamnesis:
- life events of the last 5 – 10 years
- model dimension, genogramm
- WIPPF – actual capacities, DAI, key conflict, basic conflict
- Psychic results of observation, conclusion of the symptoms, diagnosis of disorders

3. Which contents have been consulted:
- concepts/attitudes/behaviour patterns
- coping possibilities, self help
- four areas: energy model, four areas of conflict processing
- which function had the symptoms and conflicts?
- how was involving of partners, family, working group, friends possible?

4. Which impulses/changes were caused by the consultation?
- name difficulties, resistance, resources, activity, self help
- how was the process of consultation? (which progress has been obtained?)
- which restraining or promoting aspects accompanied the consultation?
- how was the time structure of the consultations (frequency)

5. Initial goals – developing of new goals – results – evaluation
- which had been reached in which amount from client's and from your point of view?
- which further goals became important during consultations?
- in which way the client gave personal feedback and evaluation?
- which form of evaluation of the results had been useful?
- how was the experience for you personally during the consultations?
- which are the most important aspects, which you learned during the consultations?