



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 you have provided counseling within the past two years and has given us permission to request your input as we determine if Outward Bound is appropriate at this time. Our purpose is to place applicants on courses where they will experience a productive level of challenge and be active participants in their own and their group's growth and safety.

Course Challenges

Outward Bound courses are intentionally challenging—physically, mentally, and interpersonally. With a group of peers in unfamiliar settings, and without access to phones or technology, participants solve problems and accomplish tasks they may not believe they are capable of. By working with their group through the stressors of doubt and uncertainty, discovering and developing their internal resources and communication skills, participants complete the experience more capable, resilient and confident.

Course Environment

Courses may take place in very remote wilderness settings, possibly 24 or more hours from emergency care, or in an outdoor urban environment. Activities may include canoeing, backpacking, kayaking, sailing, winter camping, rock-climbing, challenge (“ropes”) course, community service project and a solo camping experience¹.

Criteria (Expectations) for all Participants

To be eligible for an Outward Bound course, all participants must be able to follow instructions, make safe choices, and learn to be self-reliant in basic self-care in their new environment. Skills instruction begins at the beginner level, and participants must be able to acquire and reliably perform course skills and meet behavioral expectations. They must be able to engage positively and respectfully with a diverse peer group, tolerate periods of frustration, failure, discomfort (cold, wet, hot, buggy, hungry, muddy), and endure long hours of mental and physical effort. Participants may confront fears (heights, water, trusting others, solitude) and must cope effectively with stress. The group functions as an intact unit and the course progression depends on the positive participation of all members. Although instructors will make reasonable individual accommodation to enable group success, students who cannot engage safely or productively will be dismissed.

Instructors

Our instructors are not counselors or therapists. Instructors teach course skills, model expected behaviors, coach each participant to recognize and reach beyond self-imposed limits, and facilitate the group's progression. Group discussions provide opportunities for processing events and resolving conflict, but instructors do not endeavor to control the outcome in any prescribed therapeutic way.

Outward Bound is NOT wilderness therapy. (Such programs have a trained counselor with or available to the group). By completing this questionnaire, you will assist us to determine if your client is ready to participate in creating a safe and positive Outward Bound experience at this time.

Thank you!

The Admissions Team

¹ Solo is 6-72 hours of alone time for introspection, quiet, rest and journal writing. Participants have shelter, water and some food, are checked daily by instructors and have a means of communicating in an emergency.

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 _____ |
| <input type="checkbox"/> < 3 months | <input type="checkbox"/> < 3 months |
| <input type="checkbox"/> 3-6 months | <input type="checkbox"/> 3-6 months |
| <input type="checkbox"/> 6-12 months | <input type="checkbox"/> 6-12 months |
| <input type="checkbox"/> > 1 year | <input type="checkbox"/> > 1 year |

Indicate the DURATION of each diagnosis.

DURATION: How long has the individual had this condition?

- | | |
|--------------------------------------|--------------------------------------|
| DIAGNOSIS _____ | DIAGNOSIS _____ |
| <input type="checkbox"/> < 3 months | <input type="checkbox"/> < 3 months |
| <input type="checkbox"/> 3-6 months | <input type="checkbox"/> 3-6 months |
| <input type="checkbox"/> 6-12 months | <input type="checkbox"/> 6-12 months |
| <input type="checkbox"/> > 1 year | <input type="checkbox"/> > 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. _____

- | | |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> < 1 month | <input type="checkbox"/> < 1 month |
| <input type="checkbox"/> < 3 months | <input type="checkbox"/> < 3 months |
| <input type="checkbox"/> 3-6 months | <input type="checkbox"/> 3-6 months |
| <input type="checkbox"/> 6-12 months | <input type="checkbox"/> 6-12 months |
| <input type="checkbox"/> > 1 year | <input type="checkbox"/> > 1 year |

3. _____ 4. _____

- | | |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> < 1 month | <input type="checkbox"/> < 1 month |
| <input type="checkbox"/> < 3 months | <input type="checkbox"/> < 3 months |
| <input type="checkbox"/> 3-6 months | <input type="checkbox"/> 3-6 months |
| <input type="checkbox"/> 6-12 months | <input type="checkbox"/> 6-12 months |
| <input type="checkbox"/> > 1 year | <input type="checkbox"/> > 1 year |

SYMPTOMS (OBSERVED/REPORTED)

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

LIST 1

- 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

ADDITIONAL INFORMATION

1. Please describe the strengths your client would bring to an Outward Bound program, referencing the description of criteria for participation on page 1.

2. Please describe your client's current ability to meet challenges (physical, mental and interpersonal), referencing the description of course challenges on page 1.
 - a. Under the course conditions described, would you expect your client to display any unproductive behaviors and symptoms? (What might the instructors observe?)

3. Please describe any coping skills your client uses to handle stress, anxiety or other symptoms.
 - a. If these coping skills are not available on course (where they will not have access to phones or technology, psychologically-trained personnel, or freedom to dissociate from the group for more than a few minutes), what substitute coping skills do you feel your your client can learn effectively prior to course start?

 - b. What accommodations might your client need to participate in this course? (Accommodations that fundamentally change the nature of course or negatively impact the safety of your client or others are not able to be considered.)

4. Has your client's condition manifested in ways with direct implications to their physical health - such as suicide ideation/attempts, eating disorders, substance use/abuse, poor self-care and/or need for hospitalizations? Please describe any self-destructive behaviors your client exhibits (or has exhibited), or check NONE. Include a brief timeline, if possible.
 - a. Do you regard the client as currently stable regarding these behaviors? Yes No. Please describe.

 - b. Has your client recently been successful with increased challenge, including exposures to stressors equal or greater in intensity to those that precipitated self-destructive behaviors?

5. In your opinion, does your client currently have the ability to safely participate in a challenging Outward Bound course, with only occasional 1:1 support from instructors? (see description, page 1) Yes No. Please describe.
 - a. If yes, what advice do you have for the instructors to help your client be successful on an Outward Bound experience?

 - b. If no, what about the program is not a good fit for your client's current capacity? (Information you provide here may help us suggest a different type of course, or suggest a time for your client to reapply.)

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. Feel free to add additional pages, if needed.

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.