Adult/Adolescent CBIT Initial Evaluation

ABOUT THE SESSION

Length of session:

◯ 15 minutes ◯ 30 minutes ◯ 45 minutes ◯ 60 minutes

Place of service:

◯ Telehealth ◯ Office

Date of evaluation: _____ dd / mm / yyyy

CLIENT INFORMATION

Client name: _____ **Date of birth:** _____ dd / mm / yyyy

Chronological age: _____ **Referring physician:** _____

Diagnosis:

- ☐ Chronic Tic Disorder F95.9
- ☐ Tourette Syndrome F95.2

Co-occurring conditions:

- ☐ ADHD
- ☐ ADD
- ☐ Anxiety
- ☐ Depression
- ☐ OCD
- ☐ OCB
- ☐ Sensory Processing Difficulties
- ☐ Social Skill Difficulties
- ☐ Autism Spectrum Disorder
- ☐ Behavioral Issues
- ☐ Learning Disability
- ☐ Other

REASON FOR REFERRAL

Please provide more details:

MEDICAL/DEVELOPMENTAL HISTORY

Hospitalizations, surgeries, illnesses:

Current living situation:

Age of onset and tic progression:

Family history of tics or co-occurring conditions:

Current medications/dosage:

Sleep history:

ACADEMIC INFORMATION

Please provide more details:

VOCATIONAL/EMPLOYMENT INFORMATION

Please provide more details:

CBIT PROGRAM INFORMATION

Is the client aware of their tics?: _____ Is the client in any pain or physical discomfort due to their tics?: .

Is the client's sleep compromised due to their tics or co-occurring conditions?: Is the client's social relationships impacted by their tics?:

Does the client have hobbies or leisure activities they currently participate in? Are these activities impacted by their tics?: _____

OBJECTIVE INFORMATION

Please provide more details:

ASSESSMENTS

Check all that apply:

- [ ] Adult Tic Questionnaire (ATQ)
- [ ] Occupational Self Assessment (OSA)
- [ ] Premonitory Urge Scale (PUTS)
- [ ] Tic Hierarchy/Subjective Units of Distress Rating Scale (SUDS)

ATQ RESULTS

Motor Tic Severity: _____ **Vocal Tic Severity:** _____

Total Tic Severity: _____

OSA RESULTS

Client currently experiences difficulty with:

- [ ] Concentrating on my tasks
- [ ] Taking care of the place where I live
- [ ] Taking care of others for whom I am responsible
- [ ] Managing my finances
- [ ] Expressing myself to others
- [ ] Identifying and solving problems
- [ ] Getting done what I need to do
- [ ] Handling my responsibilities
- [ ] Doing activities I like
- [ ] Making decisions based on what I think is important
- [ ] Effectively using my abilities
- [ ] Physically doing what I need to do
- [ ] Taking care of myself
- [ ] Getting where I need to go
- [ ] Managing my basic needs (food, medicine)
- [ ] Getting along with others
- [ ] Relaxing and enjoying myself
- [ ] Having a satisfying routine
- [ ] Being involved as a student, worker, volunteer and/or family member
- [ ] Working towards my goals
- [ ] Accomplishing what I set out to do

Please provide an importance rating for items checked above:

OSA SCORES (COMPETENCE)

Total Score: _____ **Client Measure:** _____

Standard Measure: _____

OSA SCORES (VALUE)

Total Score: _____ **Client Measure:** _____

Standard Measure: _____

PREMONITORY URGE SCALE

The client's PUTS score is listed below: _____

TIC HIERARCHY WITH SUBJECTIVE UNITS OF DISTRESS RATING SCALE

The client's Tic Hierarchy and SUDS ratings are listed below:

ASSESSMENT

Please provide more details:

RECOMMENDATIONS

Based on the above assessment results, the following is recommended:

- [ ] Occupational therapy intervention with a focus on CBIT for 30-60 minutes treatment sessions 1 to 2 times as week
- [ ] Provide a home program for awareness training
- [ ] Provide a home program for competing response training
- [ ] Provide a home program for arousal management/self-regulation training
- [ ] Follow up with a Cognitive Behavioral Therapist to address mental health concerns
- [ ] Patient is not an appropriate candidate for CBIT at this time due to decreased body awareness and/or motor planning difficulties. Recommended to follow up with CBIT as needed in the future when client demonstrates improved awareness of skills mentioned.

Additional comments for recommendations above: