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# TeleMental Health Fitness Assessment for Clients

**(Revised 11/06/2019)**

Client Name: ____________________________________________ Date: ______________

*** Each question must be answered to determine clients' appropriateness for TeleMental Health treatment. ***

**Client Safety:** **Circle**

1. Is the client under the age of legal consent? Yes / No
2. If the client is under legal age of consent, is/ are client's parent(s) or legal guardian(s) willing to have telemental health services provided? Yes / No
3. Is the client suicidal or homicidal or at high risk of harming self or others? Yes / No
4. Is the client psychotic or paranoid (worried that authorities will be listening or electronic devices may harm him/her in some way)? Yes / No
5. Is the client willing to let the therapist know his/her location (address) for each session? Yes / No
6. Is, and has the client willingly provided the therapist a name and phone number an Emergency contact person on the Client Authorization & Consent To Treatment form? Yes / No
7. Does the client have a place to conduct a TeleMental Health session that is confidential? Yes / No
8. Is the client in a domestic violence or abusive situation where his abuser could find out that TeleMental sessions were occurring and result in more violence?
   a. If email or texting is part of treatment, does abuser have access to these accounts? Yes / No / N/A
   b. If the telephone is involved, does the abuser have access to the history on client's phone or information on phone bill? Yes / No / N/A
   c. If chat rooms, client portals, websites, apps, etc. are going to be used, does the abuser have access to the electronic device the client will use and associated history of where client has been online? Yes / No / N/A
9. Client is willing to provide proof of identity via photo I.D. and security word? Yes / No
10. The client has provided the following security word as proof of identity: ___________________________.

**Client's Presenting Concern & Appropriateness:**

1. Is the client avoiding something by not coming to sessions in person (e.g., not facing a driving phobia, is socially anxious, has attachment issues, has an alcohol use disorder and doesn't want the therapist to smell his/her breath, etc.) Yes / No

2. In general, is TeleMental Health therapy a solid option for this client's presenting concern and the therapist can document the rationale? Yes / No
3. Is there any language barrier/cultural issue/medical or physical issue that may cause difficulty in utilizing TeleMental health interventions? Yes / No

**Client's Technological Ability:**

1. Is the client willing to have the initial session in person or via video-conferencing in order to see client and check identification? Yes / No
2. Does the client have the technology needed to engage in the type of TeleMental Health you are offering (computer, internet, smart phone, appropriate software, etc.)? Yes / No
3. Is the client willing to use the appropriate software to maintain confidentiality? Yes / No
4. Does the client have the skill to use the means of receiving TeleMental Health services as proven by testing the technology with you or a friend prior to your session? Yes / No
5. Is the client willing to use a code word or phrase each session to ascertain identity? Yes / No
6. Has the client been informed of the procedures in case of a technological interruption of services, the client is comfortable with the protocol, and the possible interruption of services is not too stressful for client? Yes / No

**General Information:**

1. Has the client been informed as to whether insurance will cover TeleMental Health sessions or not? Yes / No
2. Will the client be in a state where you are licensed or have temporary authority to practice? Yes / No

________________________________________ _______________

Client Name (Please Print) Date

________________________________________ _______________

Parent or Legal Guardian Name (Please Print) Date

________________________________________

Client or Parent/Legal Guardian Signature

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

________________________________________ _______________

Therapist’s Name (Please Print) Date

________________________________________

Therapist’s Signature