

Choices Counseling & Resource Center, PA  
SCREENING FORM

**PLEASE PRINT CLEARLY**

Name (first, middle initial, last) \_\_\_\_\_  
DOB (mo/day/yyyy) \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Telephone(s): Home: \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Guardian/Person Responsible for Account (circle one): self parent spouse  
Parent/Spouse Name (if applicable): \_\_\_\_\_  
Signature of Person Responsible for Payment: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION (please list two people in case of emergency)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN AND/OR PSYCHIATRIST:**

**Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_  
**Psychiatrist:** \_\_\_\_\_ Phone: \_\_\_\_\_

Signature here indicates permission for Choices Counseling & Resource Center, PA to contact the above listed physician (s) for purposes of client care coordination:

\_\_\_\_\_

**EMPLOYMENT INFORMATION (for clients under 18, list parent place of employment):**

Client/Guardian: \_\_\_\_\_ Spouse: \_\_\_\_\_

**INSURANCE INFORMATION (we will file insurance but primary responsibility for payment remains with client/guardian)**

Name of Insurance Company: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_  
Insured DOB: \_\_\_\_\_  
Insured SSN: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_  
Group ID: \_\_\_\_\_  
Subscriber ID: \_\_\_\_\_

**REFERRAL SOURCE**

How did you hear about our clinic? Check all that apply:  
Phone Book \_\_\_ Website \_\_\_ Primary Care Physician \_\_\_  
Friend (please name) \_\_\_\_\_ Other \_\_\_\_\_  
Please provide name, if applicable: \_\_\_\_\_

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**MEDICAL HISTORY:**

Please describe your physical health: (check one) excellent \_\_\_ good \_\_\_ fair \_\_\_ poor \_\_\_

Allergies? Yes \_\_\_ No \_\_\_ If yes, explain: \_\_\_\_\_ Tobacco use? Yes \_\_\_ No \_\_\_

Medications:

Drug	Dosage	Purpose	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*The remainder of this form must be completed prior to the first session or with the assistance of your counselor. If you have questions, please ask. Clients under 18 may opt to complete this section during the first session.*

FAMILY INFORMATION	NAME	AGE	LIVING WITH YOU?
Mother	_____	_____	yes ___ no ___
Father	_____	_____	yes ___ no ___
Spouse/Partner	_____	_____	yes ___ no ___
Siblings and/or Children	_____	_____	yes ___ no ___
	_____	_____	yes ___ no ___
	_____	_____	yes ___ no ___

If married, number of years: \_\_\_\_\_

Other significant relationships (names/relationship only): \_\_\_\_\_

**COUNSELING HISTORY**

Have you ever been to counseling for any reason? Yes \_\_\_ No \_\_\_

If yes, for what reason? \_\_\_\_\_

Who was your counselor? \_\_\_\_\_ How long did you attend? \_\_\_\_\_

Have you ever been hospitalized for mental illness or substance abuse? Yes \_\_\_ No \_\_\_

If yes, for what reason? \_\_\_\_\_ How long were you in treatment? \_\_\_\_\_

Facility Name: \_\_\_\_\_ Dates of treatment: \_\_\_\_\_

When you were discharged, did you attend outpatient counseling? Yes \_\_\_ No \_\_\_

Name of counselor: \_\_\_\_\_

**LIFE HISTORY (issues, circumstances, problems - past or present)**

**Circle all that apply and/or add anything not listed here**

Losses

death of family member    divorce    separation    broken engagement  
miscarriage/abortion/infertility    bankruptcy    homelessness    career/job Loss

Victimizations

child or spousal abuse: physical - verbal - emotional - sexual  
abandonment    rape/assault    suicide/suicide attempt  
major illness due to: disease or accident    physical disability

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**LIFE HISTORY (cont'd)**

**Problems (that currently concern or worry you)**

**Relationships with:**

spouse      parents      children      siblings  
friends      extended-family      co-workers      teachers

**Other problems:**

infidelity      substance use (alcohol/street drugs/prescription drugs)  
eating issues (binging/purging/excessive dieting)  
depression      anger      anxiety      stress      grief      fear      loneliness  
school/academic problems (low grades, test anxiety, peer problems)  
other: \_\_\_\_\_

**Current Symptoms (as they apply to you today)**

**Mood:** sad      elated      hopeless      low energy      poor concentration      angry

**Anxiety:** worry      panic      fearfulness      compulsive

**Thought:** depression      hallucinations      obsessive      distractible

**Behavior:** aggressive      truant/runaway      disorganized      compulsive

**Sleep:** (describe) \_\_\_\_\_

**Appetite:** (describe) \_\_\_\_\_

**Other symptoms not listed:** \_\_\_\_\_

**Intense Emotional Distress: Explain below anything that is currently happening or has happened in the last two weeks.**

Suicidal thoughts/plans/attempts: \_\_\_\_\_

Homicidal thoughts/plans/attempts: \_\_\_\_\_

Desire to cause pain to self or others: \_\_\_\_\_

In fear for own life or own safety: \_\_\_\_\_

Too depressed to care for self or family: \_\_\_\_\_

*Therapist use only: reviewed in session – initial here \_\_\_\_\_ date/time \_\_\_\_\_*

**Briefly state why you are coming to counseling:**

**State three goals you hope to accomplish:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**THE CONTENTS OF THIS SCREENING FORM ARE CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT WRITTEN PERMISSION FROM CLIENT/PARENT/GUARDIAN.**