

Choices Counseling & Resource Center, P.A.
Screening Form
THIS SHEET MUST BE FILLED IN COMPLETELY

Please Print Clearly

Office Use Only: New Client: Yes No Case # _____

Date _____ Client's Social Security # _____
 Client's First Name _____ Last Name _____ MI _____
 Address _____ City _____ State _____ Zip _____
 Telephone (Home) _____ (Work) _____ (Cell) _____
 Birthdate(mm/dd/yyyy): _____ Age _____ Gender F M Marital Status: S/M/D/W Student: yes/no
 Name of Spouse/Guardian _____ Phone _____
 Address _____ City _____ State _____ Zip _____
 Person Responsible for Payment _____ Soc. Sec. # _____
 Signature of Person Responsible for Payment X _____ (Must be signed for services to begin)

A complete explanation of our financial and other policies is available in our lobby, at our website (www.choicescrc.com), or by request.

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____ Work _____
 Address _____ City _____ State _____ Zip _____
 Name (2) _____ Relationship _____ Phone _____ Work _____
 Address _____ City _____ State _____ Zip _____

Physician _____ Phone _____

Psychiatrist _____ Phone _____

Please complete medical and life history on the following pages.

Employment Information (If client is under the age of 18, use parent's employment)

Client/Guardian: Place _____ Phone _____
 Spouse: Place _____ Phone _____

Insurance Information

Primary Insurance _____	Secondary Insurance _____
Phone _____	Phone _____
Contract/ID# _____	Contract/ID# _____
Group/Acct# _____	Group/Acct# _____
Subscriber _____	Subscriber _____
Subscriber Date of Birth _____	Subscriber Date of Birth _____
Client's relationship to Subscriber	Client's relationship to Subscriber
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____

Referral Source

How did you hear of our clinic (or from whom)? _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Relationship to referral source _____

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Medical History:

Please describe your physical health: (check one) ___excellent ___good ___adequate ___poor

Any allergies? Yes ___ No ___ Explain if yes: _____

Are you using any prescription medication? Yes ___ No ___ (if yes, explain below) Do you use tobacco? Yes ___ No ___

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

The remainder of this form is to be completed by all adult clients. For minors (under the age of 18), the remainder of this form will be completed with the therapist in the first session.

Family Information:

Relationship	Name	Age	Living (y/n)	With you (y/n)
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Spouse	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Other significant others (list names/relationship only): _____

Counseling History:

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

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

Hospital name: _____ Dates of Treatment: _____

When were discharged, did you attend outpatient counseling? Yes ___ No ___ Name of Counselor _____

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

What Reason? _____ How Long? _____ Counselor _____

Life Issues/Circumstances/Problems (past or present):

Circle all that apply

Losses:

Death of family member /Divorce/Separation/Broken Engagement/Suicide/
 Miscarriage/Abortion/Infertility/Bankruptcy/Homelessness/Career or Job Loss/Other: _____

Victimizations:

Child Abuse (Physical/Emotional/Sexual/Incest)/Spouse Abuse (Physical/Emotional/Sexual)/
 Abandonment/Rape/Robbery/Assault/Suicide Attempt/Auto or Industrial Accident/Major Illness/Surgery

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Physical Disability/Alienation/Other: _____

Problems (that currently concern or worry you):

Relationships with: Spouse or Partner/Children/Parents/Siblings/In-Laws/Co-workers/Friends/Teachers

Other Problems: Infidelity/Alcohol/Street Drugs/Prescription Drugs/Binge Eating/ Excessive dieting and/or exercising /Shopping/Working too much / Procrastination / Communication / Depression / Anger / Grief / Stress / Fear / Gender Identity / Sex / Career / Loneliness / Mood Swings / Self-esteem / Codependency / Anxiety / Feelings about Church or God/
Other: _____

Current Symptoms:

Mood: sad / elated / hopeless / low energy / poor concentration / angry/ appropriate/ no problem

Anxiety: worry / panic / fearfulness / compulsive / none

Thought: depression / hallucinations / disorganized speech / obsessive / distractible / no problem

Behavior: aggressive / truant / runaway / disorganized behavior / compulsive / hyperactive / no problem

Sleep Problems (describe): _____

Appetite Problems (describe): _____

Other symptoms not listed above: _____

Intense Emotional Distress

Explain anything below that is happening currently or has happened within the last two weeks

Suicidal thoughts, plans, attempts: _____

Homicidal thoughts, plans, attempts: _____

Desire to cause pain to self or others: _____

In fear for life or personal safety: _____

Too depressed to care for self or family: _____

Briefly state why you are coming to counseling:

What do you hope to accomplish?

The contents of this form are confidential and will not be released without the written permission of client or guardian.