Screening Form

Date:_______________

Full Name:____

D.O.B._________________ ___Male ___Female ___Transgender ___Intersex _____

Home Address:____City State, Zip:_______________________

Mailing Address (if different):____

Home phone:_______________Cell phone:___________________ is it ok to leave a message? ___Y ___N

Emergency Contact Name:________________________________ Relationship:_______________________

Phone Number:____________________________________Address:________________________________

Is this client a child under 13: __no __ yes- Responsible Party:____________________________________

Relationship:______________________Address:____
School:___________________________ Grade:________

Who referred you? ____

Do you have a Primary Doctor? ____ Name:____

Are you a military Veteran? ____ What Branch?______ Type of Discharge:_________________

What mental health issue(s) you are seeking services for:_______________________________________

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Is the person seeking services in need of crisis services today?______________ Has the person seeking services been hospitalized in the past 6 months for mental health concerns?_____________________: where:____.

Funding Sources:

_____Medicaid (Provider One)

_____ Insurance Company:_______________________________ ID#____________________

Group #________________ Insurance Phone # _____________________________

Policy Holder: _________________________ Relationship: ____________________________

Address of Policy Holder:____

_____ Private Pay