REILLY COUNSELING CENTER
A VOLUNTEERS OF AMERICA ENTERPRISE

# REILLY COUNSELING CENTER
# SCREENING/INTAKE FORM (ADULT)

***THIS SECTION TO BE COMPLETED BY OUTPATIENT TREATMENT PERSONNEL ONLY:***

**Date Referral Received:** _____ **Date of Staff Response:** _____

□ **Referral Accepted** **Date Assessment Scheduled:** _____
□ **Referral Not Appropriate** **Alternate Treatment Recommendation:**
□**Psychiatric Hospital** □ **In Home Services** □ **Other:** _____

**Diagnostic Impression(s):** _____

**Urgent/Critical Needs of the Client:** _____

**Signature of Staff Completing Screening/Referral Form:** _____

## CLIENT INFORMATION

**CLIENT NAME:** _____ **DATE:** _____

**REFERRED BY:** _____

**HOW DID YOU HEAR ABOUT US?** _____

**Date of Birth:** _____ **Age:** _____ **Race:** _____ **Gender:** _____

**Social Security Number:** _____ **Name of primary person insured:** _____

**Insurance Number:** _____ **Cover Start Date:** _____ **Provider:** _____

**Address:** _____ **City/State/Zip:** _____

**Email Address:** _____ **Cell Phone:** _____

## EMPLOYEEMENT INFORMATION

**Please tell us if you are working: (check all that apply)**

□ **Employed** □ **Unemployed** □ **Full-time parent** □ **Volunteer of other**

**Employer:** _____ **Work Phone:** _____

## EMERGENCY CONTACT

**Emergency contact name:** _____ **Phone Number:** _____

**Relationship to emergency contact:** _____

## PRESENTING CONCERNS/REASON FOR REFERRAL

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**Please specify events that have led to your seeking (or being referred to) counseling:**_____

**Please describe your current symptoms and behaviors (level of intensity, length of time you've experienced symptoms, how often, and impact on other aspects of your life):**_____

**What strengths or resources do you have that will help you succeed in reaching your treatment goals (such as commitment, strong family support, intelligence, church, friends, etc.)?**_____

**What might be a barrier to your success in counseling (lack of social support, lack of family involvement, finances, etc.)?**_____

## SOCIAL HISTORY

**Please check the item that best describes you below:**

**□ Single □ Married □ Separated □ Divorced □ Remarried □ Partner or significant other**

**□ Widow/Widower □ Other** _____

**Please describe your current living situation: (please check all that apply)**

**□ With spouse □ With partner or significant other □ With children □ With parents □ Alone**

**□ With roommate □ Other** _____

**Type of setting in which you live, and any problems or concerns regarding the setting:** _____

## CHILDHOOD

**Where did you grow up?** _____

**Who raised you?** _____

**Did you experience divorce of your parents? □ Yes □ No**

**If they divorced, how old were you at the time of the divorce?** _____

**How many siblings do you have?** _____ **What was your birth order?** _____

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**How would you describe your childhood?** _____

**How would you describe your relationships with your parents/caregivers and siblings growing up?** _____

**Tell us about your current household:**
**Number of dependent adults:** _____ **Number of dependent children:** _____

| NAME | AGE | RELATIONSHIP |
|---|---|---|
| | | |
| | | |
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**Do any of the members of your household have special needs?** □ Yes □ **No**
**If yes, please explain:** _____

**How would you describe relationships in your current household?** _____

**Tell us about other committed relationships or marriages you have had.**
**Length of relationships:** _____

**Do you have children form previous relationships:** □ **Yes** □ **No**
**If yes, give names and ages (unless already provided above):** _____

## ETHNICITY, CULTURE, AND RELIGION

**Please share any ethnic, cultural, or religious concerns that may be helpful for your therapist to know:** _____

## MENTAL HEALTH HISTORY

**Please note any family members who have experienced the following:**

□ **Depression** □ **Bipolar/Manic Depression** □ **Anxiety (panic attacks, obsessive-compulsive disorder, phobias)**
□ **Schizophrenia** □ **Suicide** □ **Eating Disorders** □ **ADHD/ADD** □ **Gambling Addiction**

□ Drug or Alcohol abuse or dependency □ Sexual Abuse □ Physical Abuse □ Emotional Abuse
□ Neglect □ Sexual Addiction □ Other; please describe _____

_____

Please list your mental health history:

Previous psychiatric hospitalization: □ Yes □ No If yes, please list all previous hospitalizations below:
Previous mental health counseling: □ Yes □ No If yes, please list all previous mental health services below:

| PROVIDER NAME | DATES OF TREATMENT | REASON FOR TREATMENT | DISCHARGE DIAGNOSES | DISCHARGE MEDICATIONS |
|---|---|---|---|---|
| | | | | |
| | | | | |
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Current Diagnoses: _____
_____
_____

Diagnosed by: _____ _____
Physician/Psychiatrist Date of Diagnosis

## SUBSTANCE USE HISTORY

Please complete the following:

1. In the past year, have you felt that you ought to cut down on your drinking or drug use? □ Yes □ No
2. In the past year, have you had people annoy you by criticizing your drinking or drug use? □ Yes □ No
3. In the past year, have you felt bad or guilty about your drinking or drug use? □ Yes □ No
4. In the past year, have you had a drink or used drugs as an eye-opener first thing in the morning to steady your nerves, to get rid of a hangover, or to get the day started? □ Yes □ No

Please describe your current use of the following:

Yes No

☐ ☐ Alcohol _____ times per day/week/month/year (*circle one)*
How much at a time? _____ When did you first start using alcohol? _____

☐ ☐ Tobacco _____ times per day/week/month/year (*circle one)*
How much at a time? _____ When did you first start tobacco? _____

☐ ☐ Marijuana _____ times per day/week/month/year (*circle one)*
How much at a time? _____ When did you first start using marijuana? _____

☐ ☐ Other non-prescribed drugs _____ times per day/week/month/year (*circle one)*
How much at a time? _____ When did you first start using other drugs? _____

☐ ☐ Caffeine _____ times per day/week/month/year (*circle one)*
How much at a time? _____ When did you first start caffeine? _____

☐ ☐ Prescription or over the counter drugs _____ times per day/week/month/year (*circle one)*
How much at a time? _____ When did you first start using these? _____

When was the last time you used drugs or alcohol?_____

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**List any problems you have had because of drinking or drug use (with friends, family, law enforcement, work, school, etc.):**____

_____

_____

**Prior Treatment for Substance Use/Abuse: □ Yes □ No If yes, please note where treatment was provided, dates of treatment, and discharge summary/recommendations:** _____

_____

_____

**Family history of substance use? □ Yes □ No If yes, please explain:** _____

_____

_____

## MEDICATION

**Currently on medications: □ Yes □ No If yes, please complete the following:**

| MEDICATION | PURPOSE | DOSAGE | ADMINISTRATION | PRESCRIBED BY |
|---|---|---|---|---|
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## MEDICAL

**Primary Care Physician:** _____ **Office Number:** _____

**Address:** _____ **Fax Number:** _____

**History of or current medical illness or physical limitation? □ Yes □ No If yes, please clarify:** _____

_____

_____

_____

**Are you pregnant? □ Yes □ No**

## TRAUMA AND ABUSE HISTORY

**Describe any major losses (such as death, divorce, bullying, etc.):** _____

_____

_____

_____

**Describe any trauma or abuse (such as physical, sexual, or emotional abuse; assault; neglect; domestic violence; witness to abusive behavior, etc.)**

**Physical Abuse:** _____
**Sexual Abuse:** _____
**Emotional Abuse:** _____
**Neglect:** _____
**Assault:** _____
**Other:** _____

**Describe the most recent traumatic event experienced by the client:** _____
_____
_____
_____

**History of or currently experiencing nightmares, problems falling asleep, or difficulty staying asleep through the night?**
**□ Yes □ No If yes, please explain:** _____
_____

## SAFETY CONCERNS

**Have you ever thought about hurting or killing yourself, or had an impulse to do so? □ Yes □ No**
**If yes, do you have a suicide plan? □ Yes □ No**
**If so, please explain:** _____
_____

**Have you ever attempted to hurt or kill yourself? □ Yes □ No**
**If yes, please list the date and method:** _____
_____

**Have you ever harmed property or other people, or thought about causing harm? □ Yes □ No**
**If yes, please explain:** _____
_____

## EDUCATION

**Please list the highest grade level that you completed:** _____

**Do you have any learning disabilities or struggle with any of the following:**

**□ Speech □ Hearing □ Reading □ Writing □ Concentration □ Attention**

**□ Other:** _____ **□ None**

## LEGAL

**Legal Issues: □ Yes □ No Please Describe:** _____

**Name of Court:** _____ **Probation: □ Yes □ No Parole: □ Yes □ No**

**FINS: □ Yes □ No Probation Officer:** _____ **Phone Number:** _____

**Pending Charges: □ Yes □ No**

**History of legal charges due to violent behavior? □ Yes □ No Please explain:** _____

_____

**History of legal charges due to sex related offense? □ Yes □ No Please explain:** _____

_____

_____

**Application Completed By:** _____

**Date Application Completed:** _____