REILLY | COUNSELING CENTER
A VOLUNTEERS OF AMERICA ENTERPRISE

REILLY COUNSELING CENTER
SCREENING/INTAKE FORM

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:** _____

CUSTODIAL INFORMATION

Parent/Guardian: _____ **Relationship to Client:** _____

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

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

PRESENTING PROBLEMS/REASON FOR REFERRAL

Please specify primary emotional/behavioral issues: _____

_____

_____

_____

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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:**

FACILITY NAME	DATES OF ADMISSION	REASON FOR ADMISSION	DISCHARGE DIAGNOSES	DISCHARGE MEDICATIONS

Current Diagnoses: _____

_____

_____

Diagnosed by: _____ _____
Physician/Psychiatrist **Date of Diagnosis**

MEDICATION

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

MEDICATION	PURPOSE	DOSAGE	ADMINISTRATION	PRESCRIBED BY

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

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DEVELOPMENTAL HISTORY-CHILDREN/ADOLESCENTS

Were there complications at the child's birth? □ Yes □ No
During pregnancy (mother with chemical dependency, nutritional issues, illnesses, etc.)? □ Yes □ No
If yes to the above, please explain: _____

_____

_____

_____

Please note any delays your child may have had: (Check all that apply)
□ Speech; Age at which skill was developed: _____
□ Sitting, crawling, walking; Age at which skill was developed: _____
□ Toilet training; Age at which skill was developed: _____
□ Sleeping through the night; Age at which skill was developed: _____

Has your child ever been separated from either parent for a period of time? □ Yes □ No If yes, please explain: _____

_____

_____

_____

Has your child ever had problems separating from parents or caregivers? □ Yes □ No If yes, please explain: _____

_____

_____

_____

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: _____

_____

_____

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EDUCATION/EMPLOYMENT

Currently enrolled in school? □ Yes □ No **If no, please explain:** _____

Current Grade: _____ **Name of School:** _____

Special Education Services: □ Yes □ No **If yes, type of services: □ ED □ LD □ Other – please describe**

Does the client have a current IEP? □ Yes □ No

Are you currently employed? □ Yes □ No **Name of Employer:** _____

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:** _____

_____

_____

SUBSTANCE USE HISTORY

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

Client Substance use? □ Yes □ No **If yes, please complete the following:**

Substance Used	Amount	Frequency (Daily/Weekly/Monthly	Date of Last Use	Age of First Use

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

_____

_____

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ADDITIONAL HIGH RISK BEHAVIORS

Does the client have a history of suicidal ideations, self-harming behaviors, or suicide attempts? □ Yes □ No If yes, please clarify frequency, severity, and triggers to behavior, if known: _____

_____

_____

Current suicidal/homicidal ideation? Please clarify _____

Does the client have a history of homicidal or highly aggressive behavior towards others? □ Yes □ No If yes, please clarify frequency, severity, and triggers to behavior, if known: _____

_____

_____

Does the client have a history of sexually acting out or sexually aggressive behavior towards others? □ Yes □ No If yes, please clarify frequency, severity, and triggers to behavior, if known: _____

_____

_____

Application Completed By: _____

Date Application Completed: _____