2470 Windy Hill Rd. SE. Suite 104 Marietta, GA 30067 ·404.353.4795

Client's Pre-Screen / Intake Assessment

Identifying information

Client Name: ____ **Patient ID#:** ____

Date of Birth: _______________________________________ **Age:** ___________ **Gender:** ___________________________

Address: (St Name and Number, City. State, & Zip code) ____

____

Telephone (Home): _______________________________________ **Cell:** ____

Email:____

____

Insurance & Demographics Information

Do you have health insurance: Yes No

Primary Insurance

Member ID #: _______________________________________ **Group ID #:** ___________________________________

Co-Pay: _______________________________________ **Insurance Phone: #:** ____

Policyholder#: ____________________________________ **Relationship to Insure #:**___________________________________

Secondary Insurance:

Member ID #: _______________________________________ **Group ID #:** ___________________________________

Co-Pay: _______________________________________ **Insurance Phone: #:** ____

Policyholder#: ____________________________________ **Relationship to Insure #:**___________________________________

Additional Demographics

Preferred Language: ____________________________________**Martial Status** ___________________________________

Highest Level of Education Attained: _ ____

Do you have a Psychiatric Advance Directive: Yes No Not Applicable, Under 18

Are you interested in speaking with a Provider about developing one: Yes No

Do you have any difficulty reading or writing: Yes No

Reason for Visit:

Depression	Family Violence	Crisis Intervention
Grief/Loss	Substance Abuse	Behavioral Intervention
Anxiety/Stress	Domestic Violence	Educational Assessment
Child Abuse	Martial/ Relationship	Professional/Coaching
Family/ Child	Work/Occupational	School Issues
Anger Mgt	Money Managemen	Other______________________

In Your Own Words ---Reason for seeking services:

____

____

____

Employment

Current source of income, if SSI how much____:

Current Issues: ____

Military History (Individual or Spouse):

Branch of Service______________ Years _____
Current Issues: ____

Legal Issues-Are you currently on Probation/Parole or involved with Dept of Juvenile Justice: Yes No (If yes, complete the following)

Alcohol/Substance Abuse (Cirlce One)

Do you use alcohol, drugs or both? Yes No Both
If yes, what do you drink and how often? ____

Has your drinking/drugs resulted in legal problems? Yes No If yes, please explain:____
_
____
____
____
____
____
____
____
Drug or Drugs Used____
How much/how often:____

Mental Health History:

MH inpatient/outpatient:____

Diagnosis/medication:____

History of suicidal ideations/attempts, Yes No
FORMCHECKBOX

History of self-harming behavior Yes No

History of HI/violent behavior Yes No

Counseling History

1. Are you currently receiving or counseling or psychiatric care? YES NO

Services received: Individual Group Family Stating on _____/____/_____ until ____/____/_____

2. Have you ever received counseling or psychiatric care? YES NO

Services received: Individual Group Family Stating on _____/____/_____ until ____/____/_____

3. Have you ever been hospitalized for psychiatric care?YES NO

Dates Admitted? ____ .

Who is/was your Physician/Therapist ____’

Their Location and Address (If you have access to it)____

____

Contact number ____

____

<u>Current Symptoms/Behaviors</u> (Check all that applies)

Thinking	**Moods**	**Anxiety**	**Children**	
Over Thinking	Not Thinking/Impulsive	Dulissions	Sad most of the day	Excessive Worry
Excessive Fear	Oppositional toward others	Hallucinations	Hyperactive (Most of the day)	Restlessness
Disruptive Speech	Disorganized Speech	Incoherent Speech	Unable to sleep	Sleep too much
Easily Super Tired	Developmental Issues	Depression Symptoms	Children	Unable to Concentrate
School Problems	Thoughts of Death	Thoughts of harming	Physical Issues	Irritable/Annoyed
Grief Issues	Panic Attack Like Symptoms	Relationship Issues	Maladaptive	Substance/Drug Use
Gang Involvement	Threatening Behavior	Marijuanan	Opiates	Parent/Guardian Issues
Setting Fires	Ecstasy	Domestic Violence Issues	Satanic Involvement	Unable to communicate
Mean behavior to animals		Arguments/Conflicts		

Any Other issues not listed above that come to mind?

Have you experienced abuse at any other time?

a. Physical abuse	Yes	No
b. Sexual abuse	Yes	No
c. Emotional abuse	Yes	No

If yes, please explain:____

____

Do you have any history of Traumatic events?	Yes	No
Suicidal attempts	Yes	No
Suicidal thoughts	Yes	No
Homicidal thoughts	Yes	No
Physical Aggression/Violent Behavior:	Yes	No
Delusions or Obsessions	Yes	No
Are you experiencing Hallucinations (ex. auditory, visual, taste) or Illusions	Yes	No

If yes, please explain:__________________________________

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Medical History

a. Are you currently receiving Medical Treatment? Yes No
b. Have you ever been hospitalized? Yes No
c. Are you currently taking any medications? Yes No
D. Allergies YES NO To what? ____

Medical Conditions

Asthma	Disabling Condition	Migraines	Heart or Blood Pressure
Diabete	Seizures	Cancer	ADLs / Mobility
Head Trauma	Positive Tuberculosis Test	Positive Hepatitis Test	Positive HIV/AIDS Test
Positive STD Test	Pregnancy	Other Communicable Disease:	Acute/Chronic Pain

Any and all other medical conditions you have/are experiencing please write here:
____
____
____
____
____

Nutrition

Weight Loss or Gain of 10 Pounds or More in the Past Three Months	Yes	No
A Marked Change in Appetite	Yes	No
On a Special Diet	Yes	No
Dental Problems	Yes	No
Eating Habits or Behaviors that may be Indicators of an Eating Disorder, such as Bingeing or Inducing Vomiting.____	Yes	No

Personal Relationship/Family Issues: Yes No

Describe: ____
____
____

Spirituality:

Does Spirituality play a part in our life? Yes No

Do you attend CHURCH, MOSQ, TEMPLE, OTHER on a regular basis (Optional, please circle which) YES NO
How often do you go?

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Review Your application and sign the bottom, additionally if you have anything you were bot able to fit on the pages before, or need to include any additional information you may do so before the signature.

Client Printed Name:_____________________________________ Date__________

Client Signature____ Date___________

Parent/Legal Guardian Signature (if applicable): ______________________________

Additional Notes For Staff or Continued From Previous pages