Pre-screening form

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please bring this form to your first session or allow yourself 15 to 30 minutes prior to your appointment to complete the form in the office.

If the client is under the age of 12 this form needs to be filled out by the client's parent or guardian. If the client is over 12 this form can be filled out by the client with the parent/guardian's assistance if desired, or it can be filled out exclusively by the parent/guardian.

Today's Date: ___ / ___ / _____
Month Day Year

Client's Contact Information

Date of birth: _____ / _____ / _____ (Month / Day / Year)

Is this a DCFS case? If yes, please provide case number: _____

First Name: _____ **Middle Initial** _____ **Last Name:** _____

Client Gender: ❑ Male ❑ Female

Client Address: **Street**: _____ **City**: _____

State: _____ **Zip Code**: _____

Home phone number: (__ __ __) __ __ __ - __ __ __ __ Can we leave messages? ❑ Yes ❑ No

Other Phone number: (__ __ __) __ __ __ - __ __ __ __ Can we leave messages? ❑ Yes ❑ No

What times are best to leave a message? _____

Insurance

Do you, or the child, have private insurance?
❑ Yes ❑ No (Note: We can only take PPO.)

If you answered yes:
Insurance Company: _____
Policy number: _____
Group number: _____
Policy holder's date of birth: _____
Please, bring the insurance card to your appointment so that we can make a copy.

If client has Medicaid:
What is the ID #? _____
You will find this number on the back of the card. Find your name, or the child's, right next to it you will see "ID#". Write down this number. Please, bring the Medicaid card to your appointment so that we can make a copy.

Emergency Contact

Name: _____
Relationship with client: _____
Address: _____
City: _____ **State**: _____
Zip Code: _____
Home Phone: _____
Other Phone Number: _____

If the person mentioned in this section is not the legal guardian a consent for release of information will need to be signed. The client's therapist will help you with this during your first appointment.

Court Forensic Treatment

Is the client required by a court of law to receive counseling as part of a legal proceeding? ❑ Yes ❑ No
If you answered "Yes" please provide contact information for probation officer or parole officer.
Name: _____ Phone #: _____

Client Primary Language

❑ English.
❑ Spanish.
❑ Other: _____

Client's Parents Primary Language

❑ English.
❑ Spanish.
❑ Other: _____

Education

Is the client enrolled in school? ❑ Yes ❑ No If yes, what is his/her highest level of education achieved? _____ What school does he/she go to? _____
Does the client have history of academic or behavioral problems at school? Please specify: _____
_____
_____

Please, specify if client is <u>currently</u> having any of the following problems at school:

- ❑ Talking back to teachers.
- ❑ Refuses to go.
- ❑ Hyperactivity.
- ❑ Other:
- ❑ Low grades.
- ❑ Verbally or physically aggressive.
- ❑ Is frequently tardy.
- ❑ Being bullied or bullying others.
- ❑ Poor attention.
- ❑ Frequent suspensions.

If you chose other, please specify: _____
_____

If you are the guardian, do you authorize us to contact the school? ❑ Yes ❑ No

Mental Health History

Has the client been in counseling before?
❑ Yes ❑ No If yes, how many times and where? _____
_____
_____
What did you like, and dislike too, about the client's previous counseling experiences? _____
_____
_____
Has the client ever been hospitalized due to psychiatric problems? ❑ Yes ❑ No If yes, how many times and for what reasons? _____
_____

Is the client on any type of medication for emotional or behavioral problems (including over the counter)? ❑ Yes ❑ No ***If yes, please specify:***

	Name	**Dosage**	**Frequency**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

On a scale of 1 to 10, 10 being very compliant, how do you rate the client's compliance with these medications?
_____

Does the client have a psychiatrist? ❑ Yes ❑ No Name: _____ Phone #: _____
If you are the guardian, do you authorize us to contact this doctor? ❑ Yes ❑ No
If the client is not currently taking any medication for emotional or behavioral problems, are you willing to discuss this option? ❑ Yes ❑ No
Besides the client, is anyone else in the family experiencing difficulties at this time? _____
_____

Medical History

Does the client currently have any medical illnesses or problems that affect functioning? ❑ Yes ❑ No
If yes, please specify:

_____

_____

Does the client have history of significant past medical problems or conditions? ❑ Yes ❑ No If yes, specify:

_____

_____

Is the client on any type of medication for medical problems (including over the counter)? ❑ Yes ❑ No
If yes, please specify:

	Name	Dosage	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

On a scale of 1 to 10, 10 being very compliant, how do you rate the client's compliance with these medications?
_____

Does the client have a primary care physician?
❑ Yes ❑ No Name: _____ Phone number: _____
If you are the guardian, do you authorize us to contact this doctor? ❑ Yes ❑ No

Client's placement

- ❑ Client is currently living biological parents or one parent.
- ❑ Client is in joint custody with natural parents and step-parents. ***If client is in joint custody, do <u>both</u> parents consent for treatment?*** ❑ Yes ❑ No
- ❑ Client is with adoptive parents. When was client adopted? _____
- ❑ Client is in foster care. Name of foster parent: _____
- ❑ Client is in group home. Name of group home: _____
- ❑ Client has another type of placement: _____

Who is currently living with the client?

Name	Relationship	Age	
_____	_____	_____	❑ Male ❑ Female
_____	_____	_____	❑ Male ❑ Female
_____	_____	_____	❑ Male ❑ Female
_____	_____	_____	❑ Male ❑ Female
_____	_____	_____	❑ Male ❑ Female

Parents Information:

<u>Father</u> ❑ Married ❑ Divorced ❑ Separated ❑ Widower ❑ Never Married
Full Name: _____ Age: _____
Highest level of education _____ Occupation: _____
Phone number: _____

<u>Mother</u> ❑ Married ❑ Divorced ❑ Separated ❑ Widow ❑ Never Married
Full Name: _____ Age: _____
Highest level of education _____ Occupation: _____
Phone number: _____

Reasons For Seeking Treatment At This Time

Emotions

- ❑ Suicidal thoughts or behaviors.
- ❑ Homicidal thoughts or behaviors.
- ❑ Depression / Sadness.
- ❑ Hopelessness.
- ❑ Worthlessness.
- ❑ Irritability / Anger.
- ❑ Mood Swings.
- ❑ Tendency to isolate. / Withdrawn.
- ❑ Frequent crying.
- ❑ Reduced interest in things.
- ❑ Sleeping too much / too little.
- ❑ Sleeping too much / too little.
- ❑ Temper outburst / Verbal Rages.
- ❑ Poor appetite or overeating.
- ❑ Significant weight loss or weight gain.
- ❑ Fatigue, loss of energy.
- ❑ Racing thoughts.
- ❑ Cuts him/herself.
- ❑ Hyper sensitivity.
- ❑ Impulsiveness.
- ❑ Difficulties concentrating or thinking.
- ❑ Low self-esteem.
- ❑ Excessive fears.
- ❑ Flashbacks about past experiences.
- ❑ Excessive worry.
- ❑ Avoidance of certain places, situations, or people.
- ❑ Clingy.
- ❑ Panic, shortness of breath, palpitations, sweating.
- ❑ Nightmares.
- ❑ School refusal.
- ❑ Unwanted thoughts/images/memories.
- ❑ Very frequent hand-washing, cleaning.
- ❑ Obsessions with orderliness/cleanliness.
- ❑ Fear about being in open or enclosed places.
- ❑ Guarded, not willing to talk openly about his/her emotions.
- ❑ Other:_____
  _____
  _____
  _____
  _____
  _____

Behaviors

- ❑ Talks back to parents, teachers, etc.
- ❑ Refuses to do what parents, teachers or other authority figures ask him/her to do.
- ❑ Is bossy.
- ❑ Bullies, threatens, or intimidates others.
- ❑ Deliberately annoys others.
- ❑ Blames other for his/her own mistakes and behaviors.
- ❑ Aggression towards other people or property.
- ❑ Lacks remorse or guilt.
- ❑ Manipulates.
- ❑ Refuses to accept consequences for behavior.
- ❑ Initiates physical fights.
- ❑ Has been cruel to animals.
- ❑ Is deceitful or steals.
- ❑ Violates curfew.
- ❑ Is truant from school.
- ❑ Lies.
- ❑ Sets fires.
- ❑ Engages in risky behaviors.
- ❑ Runs away.
- ❑ Uses drugs or alcohol.
- ❑ Gang involvement is suspected.
- ❑ Refuses to admit there is a problem or anything he/she needs to change.
- ❑ Other:_____

Academic and Attention Problems

- ❑ Grades have dropped.
- ❑ Can't sit still / Has too much energy.
- ❑ Has difficulty paying or sustaining attention.
- ❑ Easily distracted,
- ❑ Frequently fails to complete schoolwork.
- ❑ Has difficulties organizing tasks and activities.
- ❑ Loses things that are necessary for activities.
- ❑ Blurts out answers.
- ❑ Leaves his seat in the classroom.
- ❑ Has difficulties waiting for his/her turn.
- ❑ Avoids/dislikes activities that require sustained attention.

Reasons For Seeking Treatment At This Time

Other Problems/Difficulties

- ❑ Legal problems, counseling is required.
- ❑ Sees or hears things nobody else can.
- ❑ Has language or speech problems.
- ❑ Has multiple physical complaints that can't be explained by medical problems.
- ❑ Eats too little. Has problems keeping a healthy weight.
- ❑ Has significant concern about weight or body image.
- ❑ Forces self to vomit.
- ❑ Has been a victim of abuse (Physical, emotional, sexual, etc.)
- ❑ Has witnessed domestic violence.
- ❑ Has difficulties socializing.
- ❑ Has an intellectual disability.
- ❑ Has one of the autism spectrum disorders
- ❑ Eats nonfood substances (ex. soap, chalk, batteries, paint, pencil, etc).
- ❑ Wets bed or clothes.
- ❑ Repeated passage of feces into inappropriate places (clothing, floor, etc).
- ❑ Has concerns related to sexuality or sexual orientation.
- ❑ Frequent use of alcohol and/or drugs.

Please, specify other reasons for seeking treatment that are not listed here: _____

_____

_____

_____

_____

What good things do you see in yourself as a parent/guardian and also in your child/adolescent?: _____

_____

_____

_____

_____

When is the client available for appointments?

Please, specify day and time range. _____

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

We have offices in 2 different locations, Elgin (1140 N. McLean Blvd) and Streamwood (1535 Burgundy Parkway). Which of these locations do you wish to choose?

❑ Elgin Office ❑ Streamwood Office

How did you hear about us?: _____

_____

_____

THANK YOU FOR COMPLETING THIS FORM!