

Sims Consulting & Clinical Services Inc. - Screening Form

Last Name	First Name	Middle Initial	Maiden Name
Client: _____			
Address: _____			Date of Contact: _____
		City	State Zip
Phone:(Home) _____ (Work or Cell) _____		Type of Contact: Telephone Face-to-face	
Social Security # _____ Guardian _____		Referral Source – Person, Agency, Address and Phone: _____ _____	
Age: _____ Birthdate: _____ Sex: M F			
Occupation or school and grade: _____		Employer: _____	
Marital Status: S M Sep D W Ethnicity: _____		Insurance: N Y Type: _____	
Primary Language Spoken: _____			

Chief Complaint:

Presenting Problems (circle):

As reported by: Name _____ Relationship _____ Phone _____

Danger To Self: None. Thoughts of suicide, Threats of suicide, Thoughts of death, Suicide attempt, Inability to care for self, Self harming behavior.
When? _____ Plan? _____

Past Danger to Self: None. Thoughts of suicide, Suicidal gestures ,Suicide attempts, Family history of suicide. Inability to care for self.
When? _____ Method? _____

Danger to Others: None. Thoughts to harm others, Threats to harm others, Plans to harm others, Attempts to harm others, Has harmed others,
Inability to care for others. When? _____ Plan? _____

Past Danger to Others: None. Thoughts to harm others, Threats to harm others, Plans to harm others, Attempts to harm others, Has harmed others, Inability
to care for others. When? _____ Plan? _____

Hospitalizations: Mental Health: Total admissions _____ Hospitalizations in the last 2 years? _____

SA Facilities: Total admissions _____ SA admissions in the last 2 years? _____

Seasonal Patterns? No Yes describe _____

Relationship Issues: None. Conflict with peers, Siblings, Parents, Spouse, Significant other, Children. No/Few friends. Running away from home,
Family desertion, Separation, Divorce, Visitation or custody disputes, Child neglect, Child abuse, Spouse abuse.
(If Abuse, specify _____.) Death in family, No significant relationships. Other _____

Medical Problems: None. Disabled, Hearing impaired, Recent illness, HIV, HepC, Diabetes, Pregnant, Surgery, Other _____
Physician _____ Pharmacy _____ Number _____

Current Medications: 1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Substance Use/Abuse: Current Abuse: Alcohol N Y describe _____
Amphetamines N Y describe _____
Benzodiazepines N Y describe _____
Narcotics N Y describe _____
Cocaine/Crack N Y describe _____
Marijuana N Y describe _____
Hallucinogens/Inhalants describe _____

Name: _____

Has Abused: Narcotics, Amphetamines, Hallucinogens, Inhalants, Marijuana, Cocaine, Crack, Alcohol, Benzodiazepines, Pain killers.
Other _____ Hospitalizations, Family problems, Job loss, Abuse related arrests. Other _____

Assess need for detoxification if client is currently impaired/intoxicated. Current pattern of use (what and how much): _____
Date of Last Use _____

Alcohol Level? Date _____ Time _____ Method _____ Result _____

What withdrawal symptoms has she/he had in the past?
DT's _____ Blackouts _____ Other _____

Current withdrawal symptoms: (circle those present) *If any symptoms exist, fill out the Medical Detoxification Screening Form*
None. Vomiting Sweating Agitation Tactile disturbances Auditory disturbances Visual disturbances Headache Tremors/Shakes

Depressive Symptoms: None. Sadness, Fatigue, Increased/Decreased Sleep, Increased/Decreased Appetite, Hopelessness, Loss of interest, Feelings of worthlessness, Guilt, Agitation, Poor concentration, Crying, Anger, Social isolation, Irritability,
Other _____

Anxiety: None. Anxiety, Conversion, Obsessions, Compulsions, Phobia, Multiple operations, Multiple somatic complaints, Nightmares, Panic Attacks, Separation anxiety, Soiling, Other _____

Manic-Like Behavior: None. Euphoria, Overtalkative, Sleep Loss, Grandiosity, Extravagance, Racing Thoughts, Other _____

Developmental Disabilities: None. TBI/ Head injury, Autism spectrum, Ambulatory, Verbal, Needs assistance with independent living skills, Needs assistance with ADL's, Borderline intelligence, Mental retardation/mild/moderate/severe.
Other _____

Psychotic/Organic Symptoms: None. Unmanageable, Inability to care for self, Memory deficits, Withdrawn, Wanders off, Poor personal hygiene, Does not make sense, Suspiciousness, Sleep loss, Poor judgement, Forgetfulness, Confusion, Auditory hallucinations, Visual hallucinations, Delusions, Disorientation, Other _____

Antisocial: None. Frequent lying, Stealing, Excessive fighting, Destroys property, Fire setting, Arrests, Convictions, Imprisoned, Sexually inappropriate, Exhibitionism, Uses assumed names, Acts alone in peer group, Probation, Parole, Pending charges, Physically cruel to animals, Other _____

Education Difficulties: None. Behavior problems, Academic problems, Needs/receives special education, Needs technical training, Truancy, Drop out, Suspensions, Expulsion, Other _____

ADD or ODD: None. Hyperactivity, Impulse control, Attention span, Loses temper, Argumentative, Annoys others, Blames others,
Other _____

Other Information: Homeless, Lives at shelter (which one?) _____ Lives with family/friends (Who?) _____
Phone # _____ Would you like someone to contact you about affordable housing information? _____
Financial Stress, Unemployed, Receives disability income, Cannot afford medications, Transportation problems.

Summary/Comments: _____

Urgency Designation: Emergent (assess face to face within 2 hr.) Urgent (assess face to face within 48 hr.) Routine (assess face to face within 7 days)

Consumer Choice: Has this consumer been offered a choice of providers? Yes No
Choices offered and reasons for choice are documented in: Admission assessment, Chart, Other _____

Tentative Diagnosis: _____

Disposition: Client to walk in and see _____ on _____ at _____
Client seen and given an appointment to return for _____ at _____
Client referred to another provider: Provider Name _____
Appointment date and time _____

Clinician signature and credentials: _____

Agency: _____