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 #______________________ Referral Source – Person, Agency, Address and Phone:

Guardian______________________________ ______________________________________

____

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:___________________ Record #: _______

Referral NPI: _____________ From: ____________________ Verbal ____ or Faxed: ____ Date:________

Primary Care Physician: ________________________

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, Inablity 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: ________________________________DOB: ________________Med #: ____________________Rec #:_________

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. Unmanagable, 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:____.