Screening Form—Therapy

Please note: **Filling out a screen form does not guarantee a spot. It is simply to review and see if we may be a good fit for you.**

Demographics:
Patient Name: ____**Date:** _____/_____/_______
Caller: _________________________________ **Relation to patient:**________________________
Date of Birth: _____/______/______ **Sex: M / F Age:** _______
Social Security Number:________________________

Please briefly describe your presenting concern(s):

Have you ever talked with a psychiatrist, psychologist or other mental health professional? YES NO (Please list approximate dates and reasons):

Are you being treated by any mental health professional or taking any psychiatric medications now?
YES NO :
____
____
____
______

Have you ever been hospitalized for mental health reasons? (If yes, please list approximate dates and reasons):
Do you have any significant medical issues at this time?

Contact/Billing Information:
Mailing ddress____
____
_
____
Best telephone number to reach you: ____________________________ **Is this a mobile / home / work line?**
Alternative Number: ___________________________________ **mobile / home / work**
Email address that you check regularly:
____
Primary Insurance Carrier:
____
Insurance Company Contact Number: ____
Policy Number: ____
Group Number:____
Policy Holder's Name, Date of Birth, and Social Security number, Relation to Patient:
____
____
Secondary Insurance? Y / N:
How did you hear about our clinic?____

Upload your insurance here (click on insert to upload)

Upload your driver's license here (click on insert to upload)