RHEMA Counseling & Support Services, PC
Screening & Referral Form

(Please Print)

Today's Date _____/_____/_____

CLIENT INFORMATION

Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Mailing Address	City	State	ZIP Code	Social Security	Home Phone No. ( ) May we leave a message? ❑ Yes ❑ No
❑ Physical Address (if different from mailing address)					

E-mail Address May we email you? ❑ Yes ❑ No	Cell Phone No. ( ) May we leave a message? ❑ Yes ❑ No

Occupation	Employer	Employer Phone No. ( )
Grade	School	IEP ❑ Yes ❑ No

Referred by (name): Agency:

Relationship: Email: Phone:

Other Family Members Seen Here

Parent/ Guardian Information (if under age 18)

Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Mailing Address	City	State	ZIP Code	Social Security	Home Phone No. ( ) May we leave a message? ❑ Yes ❑ No
❑ Physical Address (if different from mailing address)					

E-mail Address May we email you? ❑ Yes ❑ No	Cell Phone No. ( ) May we leave a message? ❑ Yes ❑ No

Occupation	Employer	Employer Phone No. ( )

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INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO YOUR COUNSELOR)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
Is this person a client here?	❑ Yes ❑ No		( )

Occupation	Employer	Employer Address	Employer Phone No.
			( )

Is this client covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance _____

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Subscriber ❑ Self ❑ Spo ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable) Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spo ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the counselor when applicable. I understand that I am financially responsible for any balance. I also authorize RHEMA Counseling & Support Services or my insurance company to release any information required to process my claims.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

Signature of Person Completing Form _____
(If Different From Client/Guardian) DATE:

******Medicaid Recipients Only******

List all other Providers you are currently receiving services from (excluding Primary Care Physician):

Provider: _____ Contact Name: _____ Phone _____

Provider: _____ Contact Name: _____ Phone _____

Provider: _____ Contact Name: _____ Phone _____

My signatures confirms that I am currently not receiving services from any other providers

_____ _____

Signature **Date**

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History

1. Have you had prior counseling? If so, when and with whom?

_____

_____

2. Are you currently on any medications? If so, who prescribed them? Please list what they are and what you are using them for?

_____

_____

3. Describe your current use of alcohol/drugs.

_____

_____

4. Do you have a family history of mental illness or substance abuse? If so, please explain.

_____

_____

5. Have you ever been treated for substance abuse? If so, when, where, and for what substances?

_____

_____

6. Have you ever attempted suicide or had a plan to harm yourself? When?

_____

_____

7. Do you currently have any thoughts or feelings of wanting to physically harm yourself? If so, please describe your plan.

_____

_____

8. Have you ever been diagnosed with an eating disorder? If so, please describe.

_____

_____

9. Have you been sexually abused or do you worry that you might have been?

_____

_____

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History Continued

10. Briefly describe any medical history you feel is affecting your well-being?

_____

_____

11. Has your eating and/or sleeping habits changed in the last 3 months? Please describe.

_____

_____

12. Please describe your current school/work functioning.

_____

_____

13. Please describe your social functioning.

_____

_____

14. What are your goals for counseling?

_____

_____

15. Any known allergies?

_____

16. Primary Care Physician/Practice (name, practice & location)

_____

_____

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Symptoms List

Please check the box in front of any word or phrase you feel applies to you:

	Headaches		Naïve		Memory problems
	Heart palpitations		Unattractive		Nervous
	Sleep problems		Fearful		Bored
	Wanting to hurt self		Timid		Restless
	Drug use		Poor concentration		Nightmares
	Financial problems		Worthwhile		Empty feelings
	Incompetent		Regrets for past		Fatigue
	Controlling		Misunderstood		Tense
	Shy		Sympathetic		Poor academic performance
	Don't take vacations		Intelligent		Worthless
	Confused		Fainting spell		Stupid
	Considerate		No appetite		Evil
	Disabled		Regular alcohol use		Over ambitious
	Not confident		Depressed		Good person
	Cannot make decisions		Inadequate		Dizziness
	Few friends		Disturbing thoughts		Attractive
	Stomach problems		Guilty		Lonely
	Feelings of panic		Hateful		Not loved
	Trembling		Inferior		Confident
	Unable to relax		Bad home environment		Cannot keep a job

REASON FOR REFERRAL

Include recent or past hospitalizations, legal involvements, mandated treatment and any information that may be helpful to your counselor.