Healing Horizons Screening Form

Date:_____ Relationship to Patient:_____

How did you find out about us?

☐ Referred by another doctor or provider? Name: _____

☐ Family member ☐ Friend ☐ Phone book ☐ Website ☐ Insurance Co.

☐ Other _____

Please let patient know we are not accepting Medicare or Medicaid (OHP) at this office.

Demographic Information:

Legal name: _____

Nickname: _____

If a minor, parent's name: _____

Relationship to parent: _____

Email address: _____

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____

Address: _____

HEALING HORIZONS

_____

Preferred Phone Number: _____ Cell ☐ Home ☐ Work ☐

OK to leave messages? Yes ☐ No ☐

Insurance Company: _____Secondary_____

Have you contacted your insurance to obtain coverage information? ☐ Yes ☐ No (If no recommend they do so)

Is this regarding an injury of any kind, DHS case, Workman's Comp, disability evaluation? ☐ Yes ☐ No (If yes, please describe) _____

Who is your primary care physician? _____

May we coordinate care with them? ☐ Yes ☐ No

(Over)

Clinical Information:

What type of services are you looking for? (Choose all that apply)

☐ Counseling (short term therapy for a specific issue)

☐ Psychotherapy (longer therapy that examines the person as a whole)

☐ Medication management

Why are you seeking treatment? _____

_____

Are you currently taking psychiatric medications? Please name them? _____

_____

Do you feel you are currently a danger to yourself or others or that this is an emergent situation?
☐ Yes - advise them to obtain assistance immediately through their county's crisis line or at their ER
☐ No – are you aware of your local crisis line number or how to access emergent care if you are in crisis?

Do you have a chemical dependency concern? ☐ Yes ☐ No Are you actively using? ☐ Yes ☐ No

If yes, what substances are you using? _____

Are you currently seeing another mental health provider? ☐ Yes ☐ No

If yes, who is your current provider? _____

Have you ever been treated for this problem in the past? ☐ Yes ☐ No

If yes, who treated you and when?_____

Have you ever been psychiatrically hospitalized before? ☐ Yes ☐ No

When was the last time you were hospitalized? _____

How many times have you been hospitalized? _____

Do you have any medical problems you are currently being treated for? _____

_____

Pt Instructions:
1) I will share this information with the doctor and we will let you know if we can schedule you.
2) If you have not called your insurance company to obtain coverage information, please do so.

Office Only: Patient accepted? ☐ Yes ☐ No If no, explain:_____