Outpatient Counseling

DATE:_____ **ASSIGNED TO:** _____

REFERRAL INFORMATION **OSB ID:** _____

How did you hear about us? _____

DEMOGRAPHIC INFORMATION

Client Name:_____ DOB: _____

SSN:_____ Sex: ☐ M ☐ F

Address: _____ Home #: _____

_____ Cell # _____

Email: _____

Primary Insurance Type: ☐ UBH ☐ BCBS ☐ NHP ☐ Medicaid Other_____

Member ID:_____ Group ID: _____

Copay: _____

CHIEF COMPLAINT/PRESENTING ISSUE:

_____

Previous/Current Diagnosis: _____

SYMPTOMS OF INTENSE EMOTIONAL DISTRESS (thoughts/plan/attempt)

Within the past year, have you experienced:	**(include frequency/ duration)?**	**(Scale 0-5/ 0=denied)**
Suicidal Thoughts	☐ Yes ☐ Denied	_____
Homicidal Thoughts	☐ Yes ☐ Denied	_____
Fear for own life/safety	☐ Yes ☐ Denied	_____
Desire to cause pain self/others	☐ Yes ☐ Denied	_____
Too depressed to care for self/others	☐ Yes ☐ Denied	_____

ANY LEGAL INVOLVEMENT

☐ N/A ☐ Yes, please provide details: _____

HAVE YOU SEEN A COUNSELOR IN THE PAST?

☐ N/A ☐ Yes, please provide details: _____

AVAILABILITY

Monday	Tuesday	Wednesday	Thursday	Friday
☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM