MOUNTAINEER
PSYCHOLOGICAL SERVICES

Phone Screening Form—Therapy

Patient Name: ____ **Date:** _____/_____/_______

Caller: ____________________________________ **Relation to Patient:**_____________________

Date of Birth: _____/______/______ **Sex: M / F** **Age:** _______

Social Security Number:_____________________

Please briefly describe your presenting concern(s):

____

____

____

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____

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 <u>hospitalized</u> for mental health reasons? (If yes, please list approximate dates and reasons):
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____

Do you have any significant <u>medical</u> issues at this time?

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____

____

<u>Contact/Billing Information:</u>

Mailing address:____

____

____

Best telephone number to reach you: _________________________ **Is this a mobile / home / work line?**

Alternative Number: _______________________________ **mobile / home / work line**

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?____

Clinician Requested: _____Jennifer _____ Jessica _____Hanna _____Rachel _____Ron _____Amy