REQUEST FOR SERVICES

TYPE OF SERVICE: Recovery Coaching Individual Therapy Addictions Counseling

Group Therapy CBT EMDR Assessment Family Therapy

NAME:_____

DATE OF BIRTH:_____

PRONOUNS:_____

EMAIL:_____

PHONE NUMBER:_____

CLIENT ADDRESS:_____

REFERRING PARTY INFO (If Applicable)

ORGANIZATION:_____

EMAIL:_____

CONTACT NUMBER:_____

TITLE:_____

INSURANCE

DOES THE CLIENT HAVE MEDICAID? YES NO

MEDICAID ID:_____

EMERGENCY CONTACT

NAME:_____

PHONE:_____

EMAIL:_____

RELATIONSHIP:_____

SOCIAL DEMOGRAPHICS

DO YOU HAVE CHILDREN? YES NO

ARE ANY OF YOUR CHILDREN CURRENTLY PLACED IN FOSTER CARE? YES NO

ARE YOU A VETERAN? YES NO

HAVE YOU GRADUATED HIGH SCHOOL? YES NO

DO YOU HAVE FAMILY THAT SUPPORTS YOUR RECOVERY? YES NO

SUBSTANCE USE GOALS/HISTORY

WHAT IS YOUR PRESENTING PROBLEM YOU ARE WORKING ON?_____

_____

HAVE YOU PREVIOUSLY BEEN IN TREATMENT? YES NO

IF YES WHEN?_____

WHERE?_____

AGE OF FIRST USE:_____

DATE OF LAST USE:_____

LENGTH OF CURRENT USE:_____

DO YOU HAVE A VALID ID? NONE ID DL

DO YOU NEED TRANSPORTATION RESOURCES/ASSISTANCE? YES NO

DO YOU NEED DENTAL? YES NO

VISION? YES NO

DO YOU NEED ASSISTANCE APPLYING FOR EBT/MEDICAID? EBT MEDICIAD NONE

EMPLOYMENT

EMPLOYMENT STATUS AT THE TIME OF APPLICCATION: EMPLOYED UNEMPLOYED

IF EMPLOYED, WHERE?_____

WORK SCHEDULE:_____

IF UNEMPLOYED DO YOU HAVE AN UP TO DATE RESUME? YES NO

HOW CAN WE HELP?

_____

_____

_____

_____

PHQ-9 Assessment

Over the last 2 weeks, how often have you been bothered by any of the following problems?

0 = Not at all, 1 = Several days, 2 = More than half the days, 3 = Nearly every day

Little interest or pleasure in doing things

0 1 2 3

Feeling down, depressed, or hopeless

0 1 2 3

Trouble falling or staying asleep, or sleeping too much

0 1 2 3

Feeling tired or having little energy

0 1 2 3

Poor appetite or overeating

0 1 2 3

Feeling bad about yourself, or that you are a failure or have let yourself or your family down

0 1 2 3

Trouble concentrating on things, such as reading the newspaper or watching television

0 1 2 3

Moving or speaking so slowly that other people could have noticed, or so fidgety or restless that you have been moving a lot more than usual

0 1 2 3

Thoughts that you would be better off dead, or thoughts of hurting yourself in some way

0 1 2 3

Total Score:_____

PHQ-9 Total Score Symptom Range

0-4: Minimal Depression 5-9: Mild Depression 10-14: Moderate Depression 15-19: Moderately Severe Depression 20-27: Severe Depression

GAD-7 Assessment

Over the last 2 weeks, how often have you been bothered by any of the following problems?

0 = Not at all, 1 = Several days, 2 = More than half the days, 3 = Nearly every day

Feeling nervous, anxious, or on edge

0 1 2 3

Not being able to stop or control worrying.

0 1 2 3

Worrying too much about different things.

0 1 2 3

Trouble relaxing.

0 1 2 3

Being so restless that it's hard to sit still.

0 1 2 3

Becoming easily annoyed or irritable.

0 1 2 3

Feeling afraid as if something awful might happen

0 1 2 3

Total Score:_____

GAD-7 Total Score Symptom Range

0-4: Minimal Anxiety 5-9: Mild Anxiety 10-14: Moderate Anxiety 15-21: Severe Anxiety