

Alternative Paths, Inc.
DIAGNOSTIC ASSESSMENT, PART I
Pre-Admission Screening Form

Telephone In-person Referred By: _____ TODAY'S DATE: _____

NAME: _____

ADDRESS: _____ CITY: _____ ZIP: _____ PHONE: _____

May we leave messages for you at the identified phone number? Yes No

May we mail correspondence for you at the identified address? Yes No

May we contact you by email? Yes Email address: _____ No

DOB: ____-____-____ RACE _____ GENDER: _____ MARITAL STATUS: _____

S.S.#: ____-____-____ VETERAN? Yes No SERVICE CONNECTED? Yes No

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

GUARDIAN? Yes GUARDIAN NAME/RELATIONSHIP _____ No

MEDICAL INSURANCE: Medicaid ; Medicare Part B ; Private: _____

INCOME SOURCE: Employment SSI/SSDI Spouse/Parent Support Other _____

REQUESTED SERVICES: Psychiatrist Counseling Social Rec CSP

Presenting Problem(s) _____

Past Psychiatric Hospitalizations (Where? Dates? Reason?): _____

Past Outpatient Mental Health Treatment (Where? Dates? Reason?): _____

Check if you have you ever been a client of or received services from the following agencies:

Alternative Paths ; AP Emergency Services ; ADDS ; MR/DD ; Catholic Charities ;
C-FIT ; Northland Counseling ; Medina County Jail ; Solutions

Alcohol / Drug Use or Abuse (Please explain):

Current : _____

Past: _____

Have you ever been treated for substance abuse? Yes No If yes, first age of use _____

When and Where? _____

Have you ever had Methadone treatment? Yes No When and Where? _____

Currently are you on Probation or on Parole now? Yes No

If yes, What court? _____ Who is your PO? _____

Past arrests / Criminal Record: _____

Suicidal thoughts/behavior (please explain):

Current : _____

Past: _____

Homicidal thoughts/behavior (please explain):

Current : _____

Past: _____

******(Do not write below this line. For A.P. Office use only.)******

Is applicant to be admitted to Alternative Paths? Yes No If yes, OUTCOME form A or B

If yes, Date & Time of Intake: _____ With Whom? _____

Was applicant referred elsewhere? Yes No Where? _____

Has client been given an AP EMS Dr's appt? Yes No _____

Has client been given an AP EMS OPC appt? Yes No _____

Staff Signature: _____ **Date:** _____

NOTES: _____

