

Alternative Paths, Inc.
PRE-ADMISSION SCREENING FORM

TODAY'S DATE: _____

NAME: _____ PHONE : _____

ADDRESS: _____ CITY: _____ ZIP: _____

DOB: _____ AGE: _____ RACE: _____ GENDER: _____ MARITAL STATUS: _____

SOC SEC NO: _____ VETEERAN? Yes No SERVICE CONNECTED? Yes No

MEDICAL INSURANCE: None Medicaid Medicare Part B Private _____

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

GUARDIAN? No Yes Guardian Name/Relationship _____ Phone: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS: _____ 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? No Yes Email Address: _____

REQUESTED SERVICES: Psychiatrist Counseling Individual CPST Group CPST

Referral Source: Self Family/Friend Hospital Court/Probation Jail Other agency/provider

Agency/Organization Name: _____ Contact Person: _____ Phone: _____

Reason for transfer/request at this time: _____

Release of Information Attached: Yes No

Supporting Documentation Attached: Yes No

SIGNS/SYMPTOMS (check all that apply):

Anxiety/worry Depression/sadness Repeated habits/rituals Excessive fearfulness Excessive Energy

Hear/see things that others do not Intrusive thoughts Impulsive Angry outbursts Suspicious of others

Mood Swings Change in eating pattern Change in sleep pattern Victim of abuse (physical, emotional, sexual)

PLEASE ELABORATE ON ABOVE: _____

Suicidal thoughts and/or behaviors

Current Past

Homicidal thoughts and/or behaviors

Current Past

Explain: _____

Have you ever been hospitalized for psychiatric care? Yes No

If yes, When, Where and Why: _____

Have you ever received Outpatient Mental Health Treatment? Yes No

If yes, When, Where and Why: _____

Your compliance with treatment (attending schedule appointments and/or following treatment recommendations) was?

Very Consistent Somewhat Consistent Inconsistent

Have you ever abused, misused or had concerns with drug and/or alcohol use? Yes No

In the past, was there abuse, misuse or concerns with drug and/or alcohol use? Yes No

Have you ever received drug and/or alcohol treatment (inpatient or outpatient)? Yes No

IF YES TO ANY OF THE ABOVE, PLEASE ELABORATE: _____

Do you have any pending legal charges and/or are you currently on Probation or Parole? Yes No

If yes, What Court? _____ Name/phone # of PO: _____

Do you have any past arrests/incarcerations/legal involvement? Yes No

IF YES TO ANY OF THE ABOVE PLEASE ELABORATE: _____

Please Rate the Following:

Strongly Agree Agree Neutral Disagree Strongly Disagree

I have a good support system of family and friends:

I am able to take care of my health, financial and household needs.

My mental health symptoms prevent me from functioning at home/work.

(Do Not Write Below this line. For A.P. Office use only)

INITIAL DISPOSTION (AP 023): EMS appointment Intake Committee Refer Out: _____

DATE REVIEWED BY INTAKE COMMITTEE: _____

DISPOSITION: Wait List Monitor Open to the agency Referred elsewhere Where? _____

Staff Signature: _____ Date: _____