1060 Sunset Strip, Sunrise, FL 33313
Tel (954) 333-8787 Fax (954) 333-8621

SCREENING FORM

OUT-PT. PROGRAMS: ☐ Individual/Family Counseling ☐ Substance Abuse ☐ SEED (After School Program) ☐ PSR Adults

Client Name: _____**DOB:**_____**Gender:** ☐ M ☐F

Client's Address:_____ City: _____, FL

Zip Code: _____Phone/Cell: _____ E-Mail: _____

Legal Guardian: _____ Relationship to Client: _____ Documentation? ☐ Y ☐ N

Siblings: ☐ No ☐ Yes _____

Allergies ☐ No ☐ Yes _____

Emergency Contact Name:_____ **Phone:** _____

School Name: _____ **Grade:** _____

Language of Choice: ☐ English ☐ Spanish ☐ Creole ☐ Other _____

Race: ☐White ☐African American ☐American Indian ☐Multi-Racial☐Asian or Pacific Islander ☐ Other_____

Ethnicity: ☐ Cuban ☐Mexican ☐Puerto Rican ☐Other Hispanic ☐Haitian ☐ Other_____

Insurance: ☐ Medicaid #/Plan Name _____ ☐ Self-Pay ☐ Pro-Bono

PCP's Name/City:_____Phone:_____

Please describe presenting problems (concerns, behavior, symptoms):

_____

_____

_____

☐ Decline in school functioning ☐ Decreased Grades ☐ Poor Behavior ☐ Poor School Attendance

☐ Family Problems(Describe)_____

☐ Aggressive / Disruptive Behavior ☐ Defiant ☐ Argumentative or Uncooperative ☐ Fire Setting ☐ Arrested

☐ Hyperactive / Impulsive ☐ Distracted/Poor Focusing

☐ Anxiety ☐ Irritability ☐ Worries ☐ Phobias (Describe) _____

☐ Sad Mood ☐ Depression ☐ Sleep Problems ☐ Social Isolation ☐ Poor/Increased Appetite

☐ Mood Swings ☐ Intense anger ☐ Emotional Outbursts

☐ Suicidal Ideation ☐ Homicidal Ideation ☐ Danger to Self or Others (Describe)_____

☐ Sexual Abuse Victim ☐ Inappropriate Sexual Behavior (Describe)_____

☐ Schizophrenia ☐ Hears Voices ☐ ☐ Hallucinations ☐ Delusions

☐ Dx of ID/ASD/Neurological Disorder (verbal/nonverbal/level of functioning)_____

☐ Substance Abuse (Describe current/history of use):

_____

_____

☐ Marchman/Baker Act Recent/History of (Dates Admitted/Length of Stay):

_____

_____

☐ Other (Describe)_____

Telehealth ☐ Yes ☐ No

Is client currently involved with any agency/ mental health provider (DCF, DJJ, PO, JPO. Psy, etc.) ☐ Yes ☐ No

If yes, Provider's name _____Tel. Number: _____

Referring Agency/School Name: _____ Staff's Name: _____

Phone: _____E-Mail: _____

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Result of Screening: ☐ Eligible for Program ☐ Placed on Waitlist
☐ Not Eligible (Explain):
_____

Actions Taken: ☐ Referred Out
☐ **Nova University Autism Center** 954-262-7747 (M-F 8:30a-5:00p) 7600 SW 36th Ave Davie, FL 33314
☐ **MGM Behavioral** (ABA Therapy and evaluations) 305-827-2822 (M-F 9:00a-5:00p, Sat. Appt Only) 8040 Northwest 155th St, Miami Lakes, FL 33016
☐ **BARC** (Detox/Residential/IOP/Outpatient) 954-357-4880 (M-Sun 7:00a-11:30p) 325 SW 28th St Ft Lauderdale, FL 33315
☐ **Other** (Agency Name/Phone Number/Address/Hours of Operation):_____

Name of Person Completing Form: _____ **Date:** _____