Today's date:

SpectrumTransformationGroup

CLIENT SCREENING FORM

Thank you for your interest in Spectrum Transformation Group. By filling out and submitting this form, you are letting us know you or your child is *interested* in receiving services from Spectrum Transformation Group. Your submission is not an agreement to services but rather a screening to determine if our agency is a good fit for your needs. Once this screening form is submitted, someone will contact you to discuss services.

Please mark the service(s) you are interested in:

- ☐ Intensive ABA Services
- ☐ Diagnostic Evaluation
- ☐ Social Skills Group
- ☐ Outpatient Individual and/or Family Therapy
- ☐ Group Therapy
- ☐ Mental Health Skill Building
- ☐ Intensive In-Home Counseling

Name of person filling out this form: _____

Relationship to individual seeking services: ☐ Self ☐ Parent/Legal Guardian

Name of individual who will be receiving services: _____

Age: _____ DOB: _____ Gender: ☐ M ☐ F

School: _____ Grade: _____ IEP: ☐ Yes ☐ No

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Other #: _____

Do we have your permission to leave messages at these numbers? ☐ Yes ☐ No

Email: _____

Did someone refer you to Spectrum? ☐ Yes ☐ No Who? _____

Are you covered by insurance health plan(s)? ☐ Yes ☐ No

Insurance Carrier: _____

ID Number: _____ Group Number: _____

Policy Holder: _____ Relationship to Subscriber: _____

Policy holder date of birth: _____ Policy holder social security number: _____

Phone number on the back of the card: _____

If client is a minor, marital status of parents:

- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Never married

If divorced or separated, who has *legal custody* of this child? _____

Child lives with: Mother _____% of time Father _____ % of time

Has non-custodial parent been informed of this treatment or evaluation? ☐ Yes ☐ No

Under Virginia law, parents must give consent for their child to enter into our services. If both parents will not be present for the initial session and there is joint legal custody, the absent parent will need to give verbal permission over the phone or written permission for their child to see the doctor. If you have sole legal custody of your child, we ask that you bring legal documents that attest to this fact. By law, we are not allowed to see you or your child if these requirements are not met.

☐ I understand

Briefly describe why the client is seeking services.

_____

_____

What diagnoses does the client carry? _____

Has the client ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No
If yes, dates and reasons for hospitalizations:

_____

_____

Does the client have a history of self-injurious or violent behaviors? ☐ Yes ☐ No
If yes, explain:

_____

_____

Does the client have any current or past legal issues? ☐ Yes ☐ No
If yes, explain:

_____

_____

List all current medications and dosages _____

List any medical issues we should be aware of_____