PALOMA SPARROWHAWK, LMHC
Initial Screening Form

Name: _____

Date of Birth: _____ Age: _____

Parent or Guardian Name: _____

Address: _____

Cell Phone No.: _____ Home Phone No.: _____

Insurance:_____ ID #: _____ Group #:_____

Insureds Name: _____ SSN of Client:_____

SSN of Insured: _____ DOB of Insured: _____

Employer: _____ CoPay: _____

Benefits: _____ Ded: _____

No. of visits: _____ Authorization No.:_____

Current concerns/presenting problem:

_____

_____

Current Medications:

_____

Risk Assessment:
Current suicidal ideations, intent or plan? Y _____ N _____
Cureent homicidal ideations, intent or plan? Y _____ N_____
Current uncontrolled anger or abusive behavior toward others? Y____ N____
Current substance use or abuse? Y____ N ____

For private payors, client was advised that his/her estimated fee will be $70.00 per hour.
Screeening date: _____ First Appt. scheduled for: _____
Notes:
Referred By: _____ _____

_____

_____

_____