Borealis Behavioral Health **New Patient Screening Form**

Date:

⇨**Client Name:** _____ Phone #: _____ Age: __ DOB: _____

Where in Alaska do you currently live?

Are you Legal Guardian: _____ If not, who is? _____

Client's Home Phone #: _____ Other Phone # (cell, work, msg: _____

What Insurance do you have? Details: _____ Secondary: ☐ Details _____

How did you hear about us? _____

Are you looking for Medication Mgmt.? ☐ Therapy? ☐

Please tell me a little about what is going on and why you are looking for medication management/therapy:

To ensure that we can serve you well, please answer the following questions:

How is your Sleep? Do you sleep:

Too much ☐ Y ☐ N

Not enough ☐ Y ☐ N

Can't fall asleep ☐ Y ☐ N

Wake up a lot ☐ Y ☐ N

Normal ☐ Y ☐ N

Details: _____

Do you: Over ☐ Y ☐ N or Under ☐ Y ☐ N Eat? Normal? ☐

Do you have any Crying Spells? ☐ Y ☐ N Details: _____

Do you have any Mood Swings? ☐ Y ☐ N Details: _____

Do you have any Anger problems? ☐ Y ☐ N if yes; Do you ever get violent? ☐ Y ☐ N Details: _____

Any Problems with Work or School? Details: _____

Any new stressors in last 6-12 months? ☐ Y ☐ N Details: _____

Any Family History of mental illness that you're aware of? Details:

Y N

☐ ☐ Is there an ongoing custody dispute that might require a clinician's testimony? Details: _____

☐ ☐ Is there any current legal situation in your home? Details: _____

☐ ☐ Is there any domestic violence in the home? If yes, are there children in the home? ☐ Y ☐ N
If yes, has it been reported to OCS? ☐ Y ☐ N Details: _____

☐ ☐ Have you been convicted of any crimes or any recent charges? Details: _____

☐ ☐ Are Drug or alcohol problems involved. Details: _____

☐ ☐ Is Office of Children's Services involved with the family at all? ☐ Y ☐ N
If yes, is client in foster care? ☐ Y ☐ N Siblings? ☐ Y ☐ N Details: _____

(Children Only) Is the client setting fires or cruel to animals? Details: _____

☐ ☐Have you ever been psychiatrically hospitalized?
If yes, how many times, last time, and for what? ☐ Y ☐ N Details: _____

☐ ☐ Are you currently having thoughts of suicide, of hurting yourself or someone else?
If yes, do you have a plan? ☐ Y ☐ N If yes, are you intent on acting on the plan? ☐ Y ☐ N
If yes, can you protect your own safety? ☐ Y ☐ N
If no, then refer to ER, or call police immediately.
Details:

☐ ☐ Previous Treatment. If yes, who, when why did they stop? Details: _____

Anything else the provider should know? Details: _____

Our office is on the 2nd level with no elevator, is this a problem for you? Y☐ N☐

Please note: You are not a client until seen & agree on a treatment course. If any problems arise, go to Emergency Room

-