Building Foundations Behavioral Health LLC
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***Pre-Screen**

Demographics

Date: **Admit Date:**

Client Name:

Address:

Telephone (Home): **Cell:**

Date of Birth: **Age:** **Sex:**

Email:

Social Security #:

Insurance Information & Additional Demographics

Do you have health insurance: ◯ No ◯ Yes

Additional Demographics

Preferred Language: **Marital Status:** **Highest Level of Education Attained:**

Do you have a Psychiatric Advance Directive: ◯ No ◯ Yes ◯ Not Applicable, Under 18

Do you have any difficulty reading or writing: ◯ No ◯ Yes

Presenting Condition/HPI

Reason for Seeking Treatment

Medical History

Primary Care Physician ◯ No ◯ Yes

Physical Exam within last 12 months: ◯ No ◯ Yes

Current Medications

Medication	Reason For Taking	Dose & Frequency	Prescribed By or OTC	Start Date	Stop Date	Taking As Directed	Effective

Allergies

Allergen	Type	Reaction	Severity	Date of Onset / Discovery

COVID-19

Medical Conditions

- [ ] Asthma
- [ ] Disabling Condition
- [ ] Migraines
- [ ] Heart or Blood Pressure
- [ ] Diabetes
- [ ] Seizures
- [ ] Cancer
- [ ] ADLs / Mobility
- [ ] Head Trauma
- [ ] Vision Impairment
- [ ] Hearing Impairment
- [ ] Positive Tuberculosis Test
- [ ] Positive Hepatitis Test
- [ ] Positive HIV/AIDS Test
- [ ] Positive STD Test
- [ ] Pregnancy

- [ ] Acute/Chronic Pain:

Medical / Surgical Treatment History

Medical Condition	Provider	Date	Treatment & Response

Family Medical History

Nutrition

- [ ] Weight Loss or Gain of 10 Pounds or More in the Past Three Months
- [ ] A Marked Change in Appetite
- [ ] On a Special Diet
- [ ] Dental Problems
- [ ] Eating Habits or Behaviors that may be Indicators of an Eating Disorder, such as Bingeing or Inducing Vomiting.

Behavioral Health / Substance Use History

Substance Use & Addiction

Drug of Choice 1: **Drug of Choice 2:** **Drug of Choice 3:**

Substance	Specify Type	Use	Amount, Frequency, and Route	Pattern of Use	Date of Last Use	Age of 1st Use	Age Became Problem
Alcohol		None					
Cannabis		None					
Depressants		None					
Hallucinogens		None					
Inhalants		None					

Nicotine		None					
Opioids		None					
Over-the-counter		None					
Prescription Drugs		None					
Stimulants		None					
Other		None					

Are you encountering any degree of risk when you are acquiring substances: ◯ No ◯ Yes

Family Behavioral Health / Substance Use History

Mental Health / Substance Use Treatment History

Treatment Issue	Provider	Dates	Intervention	Response

Do you have any previous Mental Health or Substance Use Diagnoses: ◯ No ◯ Yes

Legal Needs or Considerations:

Trauma, Abuse, Neglect, Exploitation: (Please describe any incidences where you have been a victim, perpetrator or witness)

Please Describe Any Current Stressors / Areas of Difficulty You Are Experiencing: