

Client Name _____

Chart # _____

Eric Hyde Counseling
8810 South Yale Ave Suite F
Tulsa, OK 74137
918-513-1351
eric@erichydecounseling.com

ASSESSMENT/ SCREENING PORTION:

Agency Name: Eric Hyde Counseling, LLC Date: _____

Name: LAST: _____ FIRST: _____ MIDDLE INT.: _____

MAIDEN: If Applicable) _____

Address/City/St./Zip/Co; _____

Phone #: _____ DOB: _____ Age: _____ Gender: Male Female

Best way to contact you? _____ Confidentiality Issues? _____

E-mail Address: _____

Can EHC contact you with appt. reminders and updates? (yes no)

If yes- email or txt: _____

How did you hear about EHC? _____

What would you like help with (reason for seeking services)?

What are your immediate/urgent needs(including medical)?

Currently receiving or past services? ___yes ___no If yes, where?: _____

Residing with: (alone, family, friends...) _____ # in household: _____

Source of Income: ___Employment ___SSI ___SSDI ___Food Stamp ___TANF ___Other: _____

Insurance: ___Private ___Medicaid ___Medicare ___Private Pay ___Other: ___

Insurance Company _____

Insurance ID# _____ SSN: _____

Referred by (Primary): _____ **(Secondary):** _____

Reason for referral: _____

Name of School attending: _____

Client Name _____

Chart # _____

Race (check all that apply): Native American/Alaskan Indian Black/African American Asian Hawaiian/Pacific Islander White Other Ethnicity: Hispanic/Latino _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone#: _____

Emergency Contact Address: _____

Guardian/Custodian: _____ Relationship: _____

Need any special help/equipment? yes no If yes, describe _____

Assessment questions- Answer yes, no, n/a (not applicable).

Behavioral/ Substance use

Within the last 90 days (3 months) have you had a significant period in which you have experienced:

1. Been preoccupied with drinking alcohol and/or using other drugs? **yes, no, n/a.**
2. Tried to stop drinking alcohol and/or using other drugs, but couldn't? **yes, no, n/a.**
3. Had problems caused by drinking/using drugs, and you kept using? **yes, no, n/a.**
4. Are you misusing and prescription medication or over the counter products? **yes, no, n/a.**
5. Problems with Gambling? **yes, no, n/a.**
6. Had problems with behavior that gets you into trouble at home/ school/ work? **yes, no, n/a.**
7. Experienced significant arguing and escalation with other people? **yes, no, n/a.**
8. Problems controlling your anger, or had volatile or violent behavior? **yes, no, n/a.**
9. Been charged with crime, been arrested, or been incarcerated? **yes, no, n/a.**

Comments on above questions:

Emotional/ Trauma

During the past year (12 months) have you:

10. Serious Depression(felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern,difficulty going about your activities)? **yes, no, n/a.**
11. Are you feeling mad, sad, hopeless, nervous, or have you had a change in your sleeping, eating, or school performance? **yes, no, n/a.**
12. Serious Anxiety of tension (felt uptight, worried, unable to relax)? **yes, no, n/a.**
13. Being prescribed medication for psychological/emotional problem? **yes, no, n/a.**
14. Thoughts of harming yourself? **yes, no, n/a**
15. Thoughts of harming others? **Yes, no, n/a**
16. An attempted suicide? **yes, no, n/a.**
17. Hallucinations (heard/seen things others don't hear/see)? **yes, no, n/a.**
18. Experienced a traumatic event, natural disaster, war, accident, injury, loss of a loved one? **yes, no, n/a.**
19. Experienced bullying or harassment that had a significant impact on your life? **yes, no, n/a.**
20. Had periods of time where you felt that you could not trust family or friends? **yes, no, n/a.**
21. Ever been afraid of your partner and/or family member? **yes, no, n/a.**
22. Ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened? **yes, no, n/a.**

Comments on above questions:

