



OFFICE USE ONLY

Date: _____ Taken By: _____
Counseling Category: [] Offender [] Victim [] FJI [] Community (all other counseling requests)

Counseling Intake Screening

Has client ever been the victim of domestic violence? [] Y [] N
Has client ever been the victim of crime, abuse, or trauma? [] Y [] N
Does client have children who have justice-involved parents/guardians? [] Y [] N

CLIENT INFORMATION

Name(s): _____ Language: _____

Mailing Address: _____
Street or PO Box City State Zip

[] SAFE TO RECEIVE MAIL? Email: _____ SAFE? [] Y [] N

Best Phone #: _____ [] SAFE TO LEAVE A MESSAGE?

Alternate Phone #: _____ [] SAFE TO LEAVE A MESSAGE?

Preferred Type(s) of Counseling: [] Family [] Individual [] Couples [] Group

Preferred days and times for appointments:

[] M [] T [] W [] Th [] F
[] Mornings [] Afternoons [] Evenings (evening appointments may be held at the Community Corrections Center Building)

Client Gender(s): [] M [] F Age(s) _____

Children? [] Y [] N Age(s) _____ Children live w/Client? [] Y [] N

Is client on parole/probation? [] Y [] N

(IF Crime Victim) Is client's offender on parole/probation? [] Y [] N [] N/A

Supervising P.O. _____ P.O. Phone: _____

Is client involved in any current legal charges/issues? [] Y [] N Explain: _____

Is client mandated to receive counseling? [] Y [] N Explain: _____

What brings client to counseling at this time? (Check all that apply)

- [] Anxiety [] Abuse [] Anger Management [] Substance Use/Abuse
[] Behavior [] Depression [] Family Issues [] School/Career
[] Grief/Loss [] Relationship [] Stress [] Trauma
[] Victimization [] Domestic Violence [] Mandated [] Suicidal Thoughts
[] Other _____

Briefly describe presenting issues: _____



Has client received services here previously? Y N Dates: _____

Counselor Name(s): _____

Is client served by social or case management agencies? (Voc Rehab, DHS, Aging/Disabilities, etc.) Y N

Agency/Services: _____

Is client currently receiving other counseling, mental health, or substance treatment services? Y N

If YES, please describe the services (location, type, focus, etc.): _____

Please read and initial the following important information about our services [Screeners: disclose and initial]:

- _____ There are no fees for our counseling services.
- _____ Our clinic is located inside the Justice Services building; which has security stations and metal detectors. Please allow extra time for this process.
- _____ A counselor will contact a client directly to make appointments. Counselors will make 3 attempts to contact a new client for scheduling.
- _____ Due to the many requests for counseling, it may take 4-5 weeks before we are able to schedule an initial appointment. If a client has not been contacted by a counselor in 4 weeks time, please call **503-846-3020** to check on wait-list status.
- _____ It is important that a client make every effort to regularly attend counseling sessions and/or provide prior notice for cancellations.
- _____ If it becomes necessary to cancel an appointment, or if there is a delay, please call the counselor or our main line, **503-846-3020**, and leave a message about the circumstances.
- _____ If a client does not call to cancel or to report a delay and/or has **not arrived** within **fifteen minutes** of the appointment time, the session will be considered a "no-show" and the counselor may not be available.
- _____ After two "no-shows," counselors may be reassigned in order to accommodate others waiting for services. However, a person is welcome to call our main line **503-846-3020** and request services when they feel they can better commit to regular counseling appointments.

Additional questions or concerns can be directed to Louise Bauschard (503-846-4806) or Marci Nelson (503-846-3021).

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Counselor Name: _____

Contact Attempt Dates: 1. _____ 2. _____ 3. _____ Appointment Scheduled? Y N

Initial Appointment Completed? Y N Initial Appointment Date: _____