Client Screening Form

Demographic Information			
Client Name:	ID#:	Date of Birth:	Age:
Address:		Phone Number:	
Gender:		Ethnicity:	
Legal Guardian:			
Insurance Company:		Medicaid Number:	

Reason for Requesting Services

Additional Needs/Concerns

Prior Diagnosis

Disposition of Referral
☐Referred for Assessment for Services/Admission ☐Placed on Waitlist ☐Referred to another provider ☐Referred to the Community Services Board

Completed By:	
Client Name Printed:	Date:
Client Signature:	Date:
Staff Name Printed:	Date:
Staff Signature:	Date: