

Referred by: _____

Date: _____

Crisis Intake Form – Adult/Minor

The information requested on this form will be kept confidential. Please fill out the form as completely as possible.

Client Information

Legal Name (First, MI, Last) _____ Rev. February 2021

Preferred Name _____ Birth Date ____ / ____ / ____ SSN ____ - ____ - ____

Street Address _____ City _____

State _____ Zip _____ Home phone _____ Cell phone _____

Email _____ May we send email correspondence Y N

For appointment reminders, may we: Call Leave a message Text None Prefer: Cell Home

Have you ever received outpatient treatment (counseling, therapy, psychiatrist) for mental health issues?

Y N If yes, when and where? _____

Have you ever been hospitalized or received inpatient treatment for mental health issues? Y N

If yes, when and where? _____

Have you previously attempted suicide? Y N If yes, please list date(s) of attempts and method used.

Do you currently have access to a firearm? Y N

Have you ever lost someone you care about to suicide? Y N

If yes, who and when? _____

Who lives at home with you? _____

Are you currently experiencing domestic violence or abuse? Y N

Are you concerned about affording treatment/would your copay be a barrier to treatment? Y N

Emergency Contact: Name _____ Contact number _____

Relationship to the client _____

SUICIDE COGNITION SCALE - SHORT FORM (SCS-S)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. No one can help solve my problems.	1	2	3	4	5
2. I am completely unworthy of love.	1	2	3	4	5
3. Nothing can help solve my problems.	1	2	3	4	5
4. It is impossible to describe how badly I feel.	1	2	3	4	5
5. I can't cope with my problems any longer.	1	2	3	4	5
6. I can't imagine anyone being able to withstand this kind of pain.	1	2	3	4	5
7. There is nothing redeeming about me.	1	2	3	4	5
8. I don't deserve to live another moment.	1	2	3	4	5
9. No one is as loathsome as me.	1	2	3	4	5

Scoring for use by therapist only:

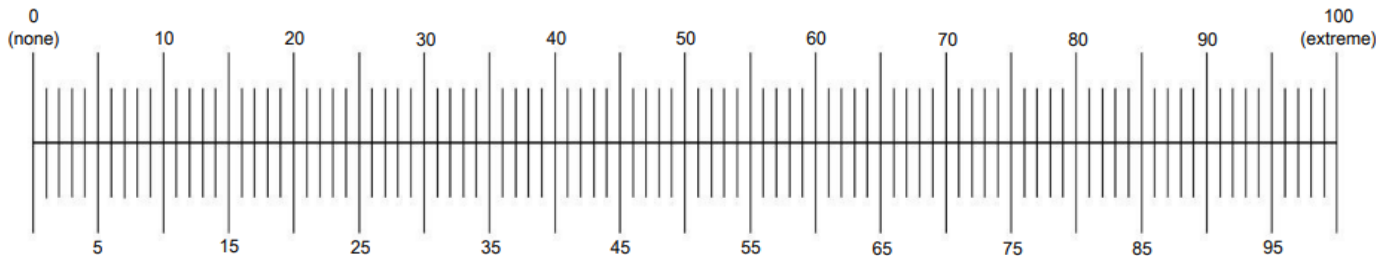
ADD COLUMNS:

+	+	+	+
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TOTAL =

SUICIDE VISUAL ANALOG SCALE (S-VAS)

Show how extreme you are experiencing the urge to kill yourself right now. Check the hash mark corresponding to the number below.



What other information is it important for your therapist to know?

If being completed for a minor, is there a legal document outlining custody? Yes _____ No _____ NA _____

Is the minor a victim of bullying? Yes _____ No _____ NA _____

Crisis Management Plan:

I understand that in the event of an emergency/crisis, or if the therapist is unable to clearly determine factors to ensure my own safety or that of someone else in the middle of my session, my therapist has the right to contact the following individuals for additional assistance:

1) Personal Contact: _____

Phone Number(s): _____

2) Personal Contact: _____

Phone Number(s): _____

3) Professional Contact: _____

Phone Number(s): _____

I understand if deemed necessary, my therapist may request a Welfare Check to be completed, contact local authorities and/or 911. Lastly, my therapist may also make recommendations for alternative treatment or refer me for a next available crisis appointment with PBCG staff.

Acknowledgement

The information written on this form is accurate, to the best of my knowledge.

Signature of Client / Guardian or Parent if client is a minor

Date



Informed Consent for Psychotherapy/Counseling & Receipt of Privacy Practices

I have been provided with a printed copy of the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet. In addition, the therapist/counselor/clinical social worker has provided a verbal explanation of psychotherapy/counseling/clinical social work services and privacy practices, to include exceptions to confidentiality. I have been afforded an opportunity to review the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet, other pertinent information, and to ask questions. All questions have been answered to my satisfaction. I am making an informed decision, free of any coercion, to engage in psychotherapeutic/counseling/clinical social work services, and for purpose of research to have my non identifiable information used. If I would like to withdraw my non-identifiable information from data collection and evaluation, I must submit this request in writing to reception@pbcg.org. I understand that I will not be denied services based on my withdrawal from data collection.

If deemed necessary or appropriate to participate in telecounseling services at Permian Basin Counseling & Guidance, I agree to the Informed Consent for Telehealth/Telecounseling provided in the Informed Consent for Psychotherapy/Counseling & Receipt of Privacy Practices. I have the opportunity to discuss the telehealth policies with my therapist and ask any questions I may have in regard to telecounseling services prior to participation.

Signature of Client / Guardian or Parent if client is a minor

Date

Signature of PBCG Staff

Date

Demographics

Gender

- Male
 Female
 Non-binary/3rd gender
 Prefer to self-describe

Prefer not to say

Sexual Orientation

- Straight/Heterosexual
 Gay or Lesbian
 Bisexual
 Prefer to self-describe

Prefer not to say

Do you identify as transgender?

- Yes
 FTM
 MTF
 No
 Prefer not to say

Preferred Pronouns: She/Her/Hers He/Him/His They/Them/ Their Other _____

Relationship status: Single Significant other Cohabiting Engaged Married
 Separated Divorced Widowed

Are you Hispanic or Latino? : Yes No Refused

Regardless of your answer to the prior question, please indicate how you identify yourself (Mark all that apply):

- Black/African American Asian White American Indian/Alaskan Native
 Native Hawaiian/Pacific Islander Other _____ Refused

Are you currently a student? : Yes No Refused

Education - Highest Level of Education Completed:

- Less than High School Diploma High School Diploma/ GED Some College, No Degree
 Associate's Degree Bachelor's Degree Graduate Degree Refused

Employment: Employed 1-39 Hours (Part Time) Employed 40+ (Full Time) Unemployed, Looking for work
 Unemployed, Not looking for work Retired Disabled, Not Able To Work Refused

Household Income: (total combined gross income of all members of a household earned in the last calendar year.)

- \$0 - \$9,999 \$10,000 - \$19,999 \$20,000 - \$29,999 \$30,000 - \$39,999 \$40,000 - \$49,999
 \$50,000 - \$59,999 \$60,000 - \$69,999 \$70,000 - \$79,999 \$80,000 - \$89,999 \$90,000 - \$99,999
 \$100,000 or more Refused

In the Past 30 Days, have you –

- Experienced Homelessness: Y N How many days: _____
 Been hospitalized for mental health/substance abuse treatment: Y N How many days: _____
 Been hospitalized for medical treatment: Y N How many days: _____
 Interacted with Law Enforcement (arrest, ticket, etc.): Y N How many days: _____

Acknowledgement

- The information written on this form is accurate, to the best of my knowledge.
 I decline to provide demographic information.

Signature of Client / Guardian or Parent if client is a minor

Date

Military Program Eligibility Form

The information requested on this form will be used to help determine eligibility for services provided to U.S. military service members and their families. Please fill out the form as completely as possible.

Client's First Name _____ Last Name _____

1. Has the client ever served in the U.S. Military? Y N

What is your current military status?

- Active Duty
 Prior Service
 National Guard/Reserves

2. Is the client related to any of the following who have ever served/or are currently in the U.S. military?

Y N

- Spouse
 Son/daughter
 Sibling
 Parent
 Grandparent

If you answered no to questions 1 or 2, you do not have to continue this form.

3. Please fill out the below for yourself the veteran sponsor's information:

a. Dates of service: from _____ to _____

b. Service Connected Disability Y N

c. Rank Enlisted Officer Warrant Officer

d. Branch Navy Marine Army Coast Guard Air Force Space Force

Eligibility of military or dependent status established by following documentation

Individuals requesting services and claiming eligibility without documentation will be granted eligibility for 3 sessions. This allows the veteran or family member to acquire proof of military affiliation. Please see example of documents below needed to verify eligibility. If individual is a family member, eligibility of the service member and the relationship to the service member is required by our grant funding this program.

Veterans

- DD Form 214, Certificate of Release or Discharge from Active Duty
- NGB-22, National Guard Report of Separation and Record of Service
- NA Form 13038, Certification of Military Service
- Department of Veterans Affairs (VA) official letter or disability letter
- E-Benefits summary letter
- Uniform Services Identification Card
- State of Texas Issued Driver License with Veteran designation
- Certificate verifying Active Duty Status from Department of Defense Manpower Data Center (ONLY –currently serving active duty)
- Tricare, Triwest, or CHAMP VA insurance

Family Member

- Uniform Services Identification Card
- Marriage Certificate - Must have one of the above with sponsors' proof of Veteran Status
- Birth Certificate - Must have one of the above with sponsors' proof of Veteran Status
- Adoption Certificate - Must have one of the above with sponsors' proof of Veteran Status
- Tricare, Triwest, or CHAMP VA insurance

Surviving Spouse

- Uniform Services Identification Card
 - Marriage Certificate - Must have one of the above with sponsors' proof of Veteran Status
 - Death Certificate - Must have one of the above with sponsors' proof of Veteran Status
 - Tricare, Triwest, or CHAMP VA insurance
-
- Copy of eligibility documents provided and included in chart**
 - Alert has been created in chart stating “needs military documentation”.**

Staff Member _____ **Date** _____