

WCSPP TREATMENT SERVICE
SCREENING REPORT

Date: _____

Patients Name: _____

Date of Birth: _____

Evaluator: _____

Supervisor: _____

Patients Address: _____

Telephone #: (H) _____ (W) _____ (C) _____

Referred by: _____

Date of interview: _____

Screening fee pd: _____ fee per session: _____ # of sessions per week: _____

(Screening fee is \$60)

(The treatment Service does not accept insurance)

Reason for Treatment Request (Chief complaint):

History of present problem (Include symptoms and precipitating stresses):

Recommendations:

Initial diagnosis: _____

Date treatment began: _____

Signature of therapist accepting case: _____

Signature of Supervisor: _____

Supervisor's comments: