

**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)

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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: