Old Mill Center for Children and Families
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Outpatient Counseling Service Request Form

Prior to services, we ask families to complete a screening tool to help us understand the current concerns and determine if we can serve the specific needs requested. After completing the Outpatient Counseling Service Request Form, we will follow up with the providers and you will be placed on our waitlist. When you are ready to be assigned our intake coordinator will contact you to update and gather the most current information and concerns as status may have changed for you during the waiting period. In the case that we are unable to provide therapy services, we can provide referrals to other providers within the community that might be a better fit. Please complete this form to the best of your ability and either mail the completed form to Old Mill Center or email to alexandra_moore@oldmillcenter.org

Date Questionnaire Completed: _____

Individual seeking services: _____

Individual's date of birth: _____ Individual's age:_____ Gender Identity:_____

Person completing form: _____ Relationship to individual: _____

Names of parents/guardians (*if individual seeking services is under 18-years-old*):

_____

Phone number: _____ Email: _____

Address: _____

Primary languages in home: _____

Preferred language of individual seeking services: _____

Will an interpreter be needed? ☐ YES ☐ NO

Interpreter Preference:

☐ Family will provide an interpreter of their choice

☐ Family requests to use Old Mill Center's interpreter service

Oregon Health Plan/IHN/Medicaid Number _____

We offer a cash pay option for families with private insurance. If this applies to you, please contact us for more information.

Counseling Service Request Form

Are you currently (or in the past) involved with any Old Mill programs? ◯ YES ◯ NO

If yes, please list which program(s):

Is the individual seeking services open to telehealth services? ◯ YES ◯ NO

If yes, do they have access to the equipment needed for telehealth (laptop, tablet, computer, headphones, and internet connection)? **A cell phone camera is not sufficient for telehealth services.*

◯ YES ◯ NO

<u>If they do not have access to sufficient equipment, telehealth services may not be provided.</u>

What is the primary goal, reason(s) or concern(s) for seeking therapy services?

How long has this been a concern/reason?

What solutions have been tried so far? Have any been effective?

If under 18-years-old Individual's current grade level _____ and school: _____

If over 18-years-old Individual's current education/employment status: _____

Counseling Service Request Form

Describe any concerns with academics or employment:

Does the individual have any academic supports (IEP, 504, or other school accommodations)?

◯ YES ◯ NO

If yes, please describe what school supports are in place?

What are the general day-to-day habits for the individual seeking services?

a. Sleep schedule	
b. Appetite and diet	
c. Hygiene (e.g., showers, teeth brushing)	
d. Physical exercise	
e. Work/school/hobbies	

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Has the individual experienced any challenging situations that could have lasting impacts on their day-to-day life?

Is the individual having difficulty with peers (bullying others, being bullied, having difficulty with peers, harassment concerns, online related concerns via social media or other platforms, other social difficulties)?

◯ YES ◯ NO

If yes, please describe the difficulties (past or present):

Are there any current or past concerns for safety (low self-control, threats to hurt self or others, aggressive behavior, suicidal thoughts, history of suicidal attempts, self-injurious behavior, and/or substance or alcohol abuse)?

◯ YES ◯ NO

If yes, please describe each concern in detail (include dates or time periods if current or in the past):

**If the individual is a danger to self or others, it is important to note that we are not a crisis service and are not equipped to provide 24-hour care or crisis interventions. In the case of a crisis or emergency; call 911, utilize the Benton or Linn County crisis lines, or to take the client to the emergency room for immediate evaluation.*

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What are the household dynamics (who lives with the individual)? If there are multiple households the client resides in, please list as well.

Person	Relationship to Client	Age	Other details (if needed)

How does the individual get along with each member living in the home?

Any pets in the home? ◯ YES ◯ NO

If yes, how does the individual interact with the pet(s)?

Has there been any past or current legal involvement (arrests, charges, probation, etc.)?

◯ YES ◯ NO

If yes, please describe:

Counseling Service Request Form

Primary Care Provider (PCP): _____

Is the individual receiving any medication or psychiatric services? ◯ YES ◯ NO

Please list any current medications below.

Medication	Dose	Diagnosis	Purpose	Prescriber

Has the individual tried therapy before? ◯ YES ◯ NO

Is the individual agreeable to therapy? ◯ YES ◯ NO ◯ MAYBE

If not (or unknown), who is requesting services and why do they differ?

Please check any mental health treatment services received in the past:

☐ Individual therapy ☐ Skills Training ☐ Residential Treatment

☐ Family therapy ☐ Day Treatment ☐ Hospitalization

What was the outcome of previous mental health treatment services?

Counseling Service Request Form

Is the individual currently receiving services? ◯ YES ◯ NO

Our therapists ask to coordinate with previous providers to streamline treatment. Please list previous providers and their contact information:

Provider/Agency Name	Address	Phone	Fax

If the individual is changing providers, is the previous therapist aware of the change? ◯ YES ◯ NO

Has there been a previous formal diagnosis (diagnoses) made by a provider (medical provider, psychiatrist, psychologist, therapist)? ◯ YES ◯ NO

[If yes, do you have previous records, assessments, evaluations] ◯ YES ◯ NO

Please list any concerns or other diagnoses and when they were diagnosed.

Medical Condition	Provider	Date of diagnosis	Status

Counseling Service Request Form

Please check any other **current** community agency involvement and your primary contact person at that agency:

- ☐ DHS _____
- ☐ CARDV _____
- ☐ CASA _____
- ☐ COI _____
- ☐ Healthy Families _____
- ☐ Jackson Street Youth Shelter _____
- ☐ Relief Nursery _____
- ☐ Occupational Therapy _____
- ☐ Boys and Girls Club _____
- ☐ Physical Therapy _____
- ☐ OSU KidSpirit _____
- ☐ Other _____
- ☐ Trillium Family Services _____

Please describe any other factors or details not covered that we should know: