



www.oldmillcenter.org **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 [hannah.altimus@oldmillcenter.org](mailto:hannah.altimus@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 are only accepting OHP/IHN (Medicaid) at this time.**

## 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):

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

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b. Appetite and diet

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c. Hygiene (e.g., showers,  
teeth brushing)

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d. Physical exercise

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e. Work/school/hobbies

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## Counseling Service Request Form

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.*

## Counseling Service Request Form

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:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Individual therapy | <input type="checkbox"/> Skills Training | <input type="checkbox"/> Residential Treatment |
| <input type="checkbox"/> Family therapy     | <input type="checkbox"/> Day Treatment   | <input type="checkbox"/> 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: