University of Evansville

Mental Health Clinic and Emily M. Young Assessment Center

Date Submitted: _____

Our purpose is to provide a hands-on training environment for future mental healthcare professionals. This clinic is operated by students in the U.E.'s Doctor of Psychology clinical degree program and it is supervised by a licensed clinical psychologist.

The students are not able to bill insurance. So, our solution is to charge a flat rate fee for therapy sessions.

A screening is required for all new clients, and it will take anywhere from 5 to 10 minutes to complete. This screening will help determine if our services are likely to meet your current needs. After completion we will then coordinate with our supervisors to pair you with an appropriate clinician if we are able. This turnaround is typically about a week but can vary depending on the time of the semester.

Client Screening Form

Name of Client: _____ **Gender Description:** _____ **DOB:** _____ **Age:**_____

Caregiver Name: _____ **Relationship:** _____ **Legal Guardian:** Yes or No

Shared Custody: Yes or No *****If guardians are separated, please provide legal documentation if there is a sole custodian. Otherwise, both parties need to provide a signature for consent for treatment.

Phone Number: _____ **Voicemail Consent:** Yes or No

Primary Care Provider: _____

Primary Insurance: _____ **Secondary Insurance:** _____

How did you hear about us? _____

Type of service pursuing:

Therapy Testing Medication Management Group Therapy

Please list your availability:

Our hours of operation are Monday 8:00am – 4:30pm & Tuesday – Thursday 8:00am – 8:00pm

We typically suggest scheduling our clients to be seen on a weekly basis. But this can be adjusted based on availability and necessity.

Monday	
Tuesday	
Wednesday	
Thursday	

Current concerns/symptoms to be addressed: (Please list current formal diagnosis)

_____

_____

_____

Any <u>current</u> treatment pertaining to concern/symptoms?

(Ex: current psychiatric medications or current therapies)

_____

_____

Any <u>past</u> psychological treatments? Yes or No

Explain: _____

Any prior psychiatric hospitalizations? Yes or No **When:** _____

Any prior psychological testing? Yes or No **Type:** _____

Any history of self-harm? Yes or No **How long ago:** _____
(Including suicide attempts)

Current substance use or abuse? Yes or No **What:** _____
(Ex: nicotine, alcohol, THC, narcotics, etc.)

Any physical health conditions?

_____

_____

Current medication list:

_____

_____

Provider gender preference:

Male Female No Preference

<u>To be completed by clinic:</u>

Based on presenting concern, provider to schedule with: Faculty Student

Date the client scheduled: _____

Whom is the client scheduled with?

<u>Method of Payment:</u>

Bill Insurance (Faculty only)
*Students are not able to bill insurance.

Pay Out of Pocket (Flat rate with students)
*Flat rate does not include Medication Management services.

No Preference