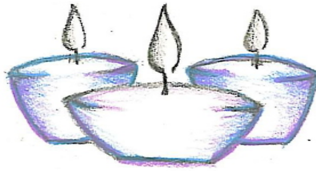
Extrordinary Counseling



"Your Lights to the future"

SCREENING

Client Name: ____

Gender: ___M ___ F Age:____ Grade/Education Level completed:___________

Any previous diagnosis:

Mental: ____

Physical: ____

Reason for seeking services:____

____

Problem and specific Events: (who, what happened, when, where and how)

____

____

____

Attempts to Resolve Current problem: (number of attempts and by what means)

____

____

What do you want to happen from treatment? :____

____

zmb/2011