

*The Center for Personal Growth*  
 4656 30<sup>th</sup> St., San Diego, Ca. 92116  
 Telephone: (619) 528-8005  
 Fax: (619) 528-8054

Before completing the initial screening form to participate in the Skills System group\*, please complete the inclusion and exclusion criteria listed below:

**Inclusion Criteria (check all that apply):**

The client is dually diagnosed (developmental disability and co-occurring psychiatric diagnosis) and be able to provide documentation of these diagnoses.  Yes  No

The client has the ability to participate in group therapy (i.e. sitting, attending, answering questions, participating, etc.)  Yes  No

The client has an open and active case with the San Diego Regional Center.  Yes  No

**Exclusion Criteria (check all that apply):**

The person has a history of being AWOL and this issue is part of the person's current treatment plan/interventions.  Yes  No

The person has a high degree of self injurious behavior management as part of their current treatment plan/interventions.  Yes  No

The person has a high degree of physical or verbal aggression, property destruction, or recent incidents as part of their current treatment plan/interventions.  Yes  No

The person has a seizure disorder not reliably controlled by medication.  Yes  No

The person requires assistance with bathroom use.  Yes  No

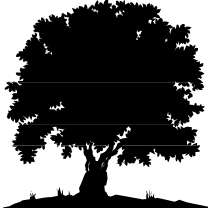
The person has a history of fire setting behavior.  Yes  No

The person has a history of inappropriate sexual behavior.  Yes  No

The person has problematic substance abuse.  Yes  No

The person does not use words to communicate and does not have appropriate facilitation available.  Yes  No

If you answered "Yes" to any exclusion criteria, please provide details: [Click here to enter text.](#)



*The Center for Personal Growth*  
4656 30<sup>th</sup> St., San Diego, Ca. 92116  
*Telephone: (619) 528-8005*  
*Fax: (619) 528-8054*

## **Skills System Group Initial Screening Form**

### **General Information:**

Name: [Click here to enter text.](#)

Address: [Click here to enter text.](#)

Telephone (Day/Evening/Cell): [Click here to enter text.](#)

Is it OK to leave a message from the Center for Personal Growth, Inc. at the telephone number listed above?  Yes  No

Date of Birth: [Click here to enter text.](#)

Type of residence: [Click here to enter text.](#)

Would you like to receive email appointment reminders from the Center for Personal Growth, Inc.?  Yes (if yes, please provide your email info. below)  No

Email (Optional): [Click here to enter text.](#)

### **Transportation:**

Do you have transportation to and from group (i.e. public transportation, MTS, support person)?  Yes  No

### **Emergency Contact Information:**

Name: [Click here to enter text.](#)

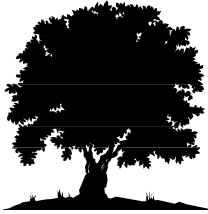
Relationship to client: [Click here to enter text.](#)

Telephone (Day/Evening/Cell): [Click here to enter text.](#)

### **Support People:**

SDRC SC: [Click here to enter text.](#) Tel.#: [Click here to enter text.](#)

Name: [Click here to enter text.](#) Tel.#: [Click here to enter text.](#)



*The Center for Personal Growth*  
 4656 30<sup>th</sup> St., San Diego, Ca. 92116  
 Telephone: (619) 528-8005  
 Fax: (619) 528-8054

Name: [Click here to enter text.](#) Tel.#:[Click here to enter text.](#)

**Legal Representative:**

Does the client have a conservator or is the client a minor who needs parental consent to receive therapy services?  Yes  No

If Yes, please provide the following information:

Name of conservator or legal representatives: [Click here to enter text.](#)

Telephone number of conservator or legal representative: [Click here to enter text.](#)

**Referral Source:**

How did you hear about this group? [Click here to enter text.](#)

**Insurance information:**

What is the name of your insurance company (i.e. Medi-cal, Medi-care, etc.)? [Click here to enter text.](#)

What is your policy/claim/case number? [Click here to enter text.](#)

\*\*\*Please Note: Please bring your insurance card or a copy of your insurance card to your initial screening appointment\*\*\*

**Mental Health History:**

What is your current Mental Health diagnosis? [Click here to enter text.](#)

When were you first diagnosed with a mental health condition? [Click here to enter text.](#)

Who diagnosed your current mental health condition? [Click here to enter text.](#)

Are you currently taking any psychotropic medications for a mental health condition? (Include over the counter medications):  Yes  No

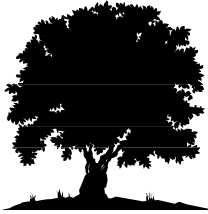
If Yes, please list those medications, dosage, and frequency: [Click here to enter text.](#)

Who is prescribing and monitoring these medications? [Click here to enter text.](#)

Have you ever been or are you currently in therapy?  Yes  No

If yes, please list the following:

Name of therapist: [Click here to enter text.](#)



*The Center for Personal Growth*  
4656 30<sup>th</sup> St., San Diego, Ca. 92116  
*Telephone: (619) 528-8005*  
*Fax: (619) 528-8054*

Telephone number of therapist: [Click here to enter text.](#)

Dates seen in therapy (if known): [Click here to enter text.](#)

Have you had any psychiatric hospitalizations?  Yes  No

If yes, please provide greater details regarding these hospitalizations such as hospital name, dates, and length of stay: [Click here to enter text.](#)

### **Medical History:**

Do you have any current medical problems? (include recent illness, injury or surgery, any allergies to medications or foods):  Yes  No

If yes, please provide details: [Click here to enter text.](#)

Are you currently taking any medications for a medical condition? (Include over the counter medications):  Yes  No

If yes, please list those medications, dosage, and frequency: [Click here to enter text.](#)

Please provide the following information:

Name of primary care physician: [Click here to enter text.](#)

Telephone number of primary care physician: [Click here to enter text.](#)

### **Substance Abuse History:**

Do you have any current alcohol and/or illicit drug use?  Yes  No

If yes, include type of drink, number of drinks and frequency, include type of drug and frequency: [Click here to enter text.](#)

Have you ever received treatment for any type of substance abuse?  Yes  No

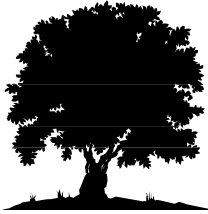
If yes, please describe the type of treatment and dates of treatment. (i.e. 12 step, inpatient treatment, outpatient therapy): [Click here to enter text.](#)

### **Reason for referral?**

For what reasons are you seeking group therapy? [Click here to enter text.](#)

What changes would you like to see take place in your life? [Click here to enter text.](#)

Please describe your current symptoms (Include emotional, physical, behavioral and relationship concerns): [Click here to enter text.](#)



*The Center for Personal Growth*  
 4656 30<sup>th</sup> St., San Diego, Ca. 92116  
 Telephone: (619) 528-8005  
 Fax: (619) 528-8054

**Risk Assessment:** (Please answer all questions based on your **current** mental state or circumstances):

Suicidal Thoughts  Yes  No      Homicidal Thoughts  Yes  No  
 Domestic Violence  Yes  No      Physical/Sexual/Verbal Abuse  Yes  No  
 Mania  Yes  No      Psychosis  Yes  No      Paranoia  Yes  No

If Yes, Please explain with dates for each incident: [Click here to enter text.](#)

Any **history** of above or attempts of the above?  Yes  No  
 If yes, please provide details: [Click here to enter text.](#)

Thank you for completing this questionnaire. All information will be used to help you and your therapist complete a thorough assessment and develop a treatment plan. By signing below you acknowledge that you understand all the questions asked on this form and that you have answered all questions honestly and accurately.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

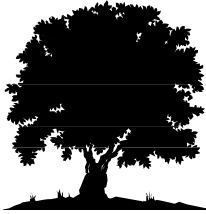
Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Conservator (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Form Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for completing the Skills System Group Initial Screening Form. Please print, sign, and fax this form to The Center for Personal Growth, Inc. at 619-528-8054. This information will be reviewed by a Skills System staff member who will contact you to discuss the content and/or schedule an initial appointment.

\*These groups are part of the Solutions Building Community Collaborative, a demonstration project of SDBHS and SDRC.



*The Center for Personal Growth*  
 4656 30<sup>th</sup> St., San Diego, Ca. 92116  
 Telephone: (619) 528-8005  
 Fax: (619) 528-8054

**Authorization To Release And Exchange Information:**

I, the undersigned, hereby request and authorize:

The San Diego Regional Center  
 4355 Ruffin Road  
 San Diego, Ca. 92123

To disclose information and exchange information and records with:

**The Center for Personal Growth, 4656 30<sup>th</sup> Street, San Diego, Ca. 92116**

I understand that the medical records and information requested may contain information pertaining to mental health, drug/alcohol related treatment and personal/family information. Additionally, results from psychological testing may also be released. It may also contain related medical information.

This disclosure of records and information authorized herein is required for the purpose of completing a comprehensive evaluation.

I specifically request that the following information be released:

- Provider Progress Notes       Physician Orders       Medication Administration Records
- School Records (IEP, etc.)       Psychological Testing Results
- San Diego Regional Center I.P.P. and other documentation.
- Other: Verbal updates and consultation with my SDRC SC.

This authorization is subject to revocation by the undersigned at any time except to the extent that action based on my authorization has already been taken. If not earlier revoked, it shall terminate twelve (12) months from the date of authorization without express revocation. I understand that revocation must be in writing. A copy of this authorization/request is to be valid as the original, and I have received a copy of this authorization.

I acknowledge that I have been advised of what information will be disclosed and understand the benefits and disadvantages of such disclosure. This authorization/consent is given freely and I have not been threatened with discontinuance or refusal of service if I do not sign this form.

**I agree that the above person/organization may FAX the above records.**

---

Name of Client (Please Print) Patient's Birth Date

---

Client's Signature Date Signed

---

Witness/Conservator (if applicable) Relation to client