Primary Behavioral Health Therapist Questionnaire (LCSW, LISW, LPC, Psychologist)

Instructions

This form should be completed and signed by your primary behavioral health therapist (LCSW, LISW, LPC, Psychologist). The completed form should be mailed to PAALS at

PAALS
221 N. Grampian Hills Rd.
Columbia, SC 29223

Therapist Information

Client Name ____

Therapist Name ____

Type of practice ____

Address ______________________________ **County** ______________

City ____________________ **State** ________ **Zip Code** ______________

Phone Numbers *Work* ______________ *Cell* ______________ *Fax* ______________

E-Mail ____

Questionnaire

Is the applicant being treated by a medication prescriber? (Psychiatrist, APRN)? *Yes* ❑ *No* ❑

If yes, Prescriber's Name ______________________________

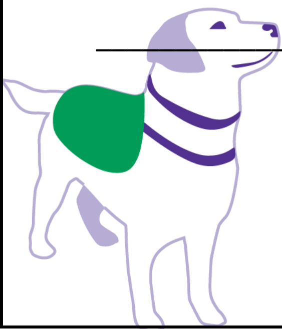
What is the applicant's primary behavioral health diagnosis? ______________________________

____

____

Secondary Diagnoses? ____

____



PALMETTO ANIMAL ASSISTED LIFE SERVICES
221 N. Grampian Hills Road, Columbia, SC 29223
Office: 803.788.7063 / Fax: 803.336.7118
info@PAALS.org
www.PAALS.org

Is the diagnosis related to: (PLEASE CHECK ALL THAT APPLY)

Military combat trauma	❑	*Spouse/partner abuse*	❑
Sexual trauma	❑	*Accident/injury*	❑
Childhood trauma	❑	*Natural disaster (flood, fire, tornado, etc.)*	❑

Are there any substance use related concerns? *Yes* ❑ *No* ❑

If yes, please explain ____

____

Is there any history of animal abuse? *Yes* ❑ *No* ❑

If yes, please explain ____

____

How long has the applicant been in treatment with you? ____________________________________

How often is the applicant seen for therapy? *Weekly* ❑ *Every Two Weeks* ❑ *Monthly or less* ❑

Is the applicant dependable in terms of keeping scheduled appointments and follow through on recommendations/out of session assignments? *Yes* ❑ *No* ❑

Has there been a lapse in treatment? *Yes* ❑ *No* ❑

If yes, how long? ____

Treatment Modality: (PLEASE CHECK ALL THAT APPLY)

- ❑ *Cognitive Behavioral Therapy*
- ❑ *Cognitive Processing Therapy*
- ❑ *Prolonged Exposure Therapy*
- ❑ *Eye Movement Desensitization and Reprocessing*
- ❑ *Cognitive Behavioral Therapy for Insomnia*
- ❑ *Alternate/complimentary approaches (yoga, biofeedback, experiential, mindfulness, art)*

Please indicate if the applicant has had or is currently receiving: (PLEASE CHECK ALL THAT APPLY)

- ❑ Individual Therapy
- ❑ Group Therapy
- ❑ Inpatient Psychiatric Hospitalization
- ❑ Residential Trauma Treatment
- ❑ Intensive Outpatient (IOP) or Partial Hospitalization (PHP)

Is there any past suicidal ideation, plan or attempt? *Yes* ❑ *No* ❑

If yes, when? ____

Current Symptoms: (PLEASE CHECK ALL THAT APPLY)

Irritability/anger	❑	*Issues causing conflict in relationships*	❑
Panic attacks	❑	*Nightmares/insomnia*	❑
Social isolation	❑	*Anxiety in public places*	❑
Depression	❑	*Avoiding places, situations, people*	❑
Sensitivity to noise/touch	❑		

Please list any known triggers for the applicant: ____

____

What are the applicant's treatment goals? ____

____

____

Please describe how you believe a service dog could be used to improve the applicant's functioning and quality of life: ____

____

If the applicant is selected to receive a service dog, would you be willing to incorporate the use of the dog into the applicant's treatment plan? *Yes* ❑ *No* ❑

Would you be willing to communicate with PAALS staff regarding any concerns, progress towards goals and the effectiveness of the service dog in improving symptoms? *Yes* ❑ *No* ❑

If yes, preferred method of contact: ____

Applicant selected to receive a service dog are required to attend a 2 week intensive team training. Would you be available to the applicant by phone during this period if needed for additional support? *Yes* ❑ *No* ❑

Therapist Signature ____

Print Name ____

Date ____