Behavioral Health /Therapist Questionnaire

This form is to be completed and signed by your primary behavioral health therapist (LCSW, LISW, LPC, Psychologist, Psychiatrist or General Practitioner under their care in the same state in which the individual currently resides.

RE: Client Name _____

Therapist Name/Credentials_____
Type of practice _____
Address_____
City _____ State _____ Zip Code _____
Phone Number Work _____ Cell _____
E-Mail _____

Questionnaire
Is the applicant being treated by a medication prescriber? Yes ☐ No ☐
If yes, Prescribers name _____
What is the applicant's primary behavioral health diagnosis? _____
_____
Secondary Diagnoses? _____

Is the diagnosis related to: (PLEASE CHECK ALL THAT APPLY)?
Military ☐ Combat ☐ Spouse/Partner ☐ Sexual ☐ Physical Abuse ☐
Accident/injury ☐ Childhood Trauma ☐ Natural disaster ☐

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 ☐ bi-weekly ☐ Monthly ☐
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 such as yoga, biofeedback, mindfulness, art, etc. ☐

Please indicate if the applicant has had or is currently receiving: (PLEASE CHECK ALL THAT APPLY)
Individual ☐ Group ☐ Inpatient Psychiatric Hospitalization ☐
Residential Trauma Treatment ☐ Intensive Outpatient ☐ Partial Hospitalization ☐

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: _____

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 BNADOG faculty regarding any concerns or progress towards goals and the effectiveness of the service dog to improving symptoms? Yes ☐ No ☐

If yes, please provide your preferred method of contact: _____

Therapist Signature _____

Print Name _____

Date _____

Contact Information:

Completed form should be sent to:
Before ~N~ After Dog Training
Belinda N. Ahern,
14 Waterhouse Ln
Chester, CT 06412