Arches Counseling and Trauma Treatment

therapeutic movement group referral

client's name		
address		
phone	okay to text? Y N	email
referred by	best contact	

Please return this referral with an Arches Counseling and Trauma Treatment registration form completed by your client. See website below to access forms.

current diagnoses
current clinical goals
somatic manifestation of trauma (eg chronic pain, insomnia)
What medical interventions are you aware of?
What physical limitations are you aware of?
How does this client get "stuck" in therapy?
What else should I know?

_____ clinician/PCP signature

_____ date

**Notes about my office:

Please note that this office is on the 3rd floor. Clients with mobility issues are encouraged to participate virtually if possible. Also, dog and food allergens may be present.

Scan the code above or check out **www.archesctt.com** for pictures of the space.

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