Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSI #: \_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_\_\_ Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Assistance #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian if the client is Under 18: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who has legal guardianship to sign treatment consent? :  Mother  Father  Both  DSS

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade: \_\_\_\_\_\_\_\_\_\_\_ General Ed/Spec. Ed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of Suspensions: \_\_\_\_\_\_\_\_\_\_ Highest Level of Education Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DSS Involvement: \_\_\_\_\_\_\_\_ DJS Involvement: \_\_\_\_\_\_\_\_ Other (Specify):\_\_\_\_\_\_\_\_\_\_

Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this client currently receiving: Therapy Psychiatric Services PRP Services None

If yes, agency name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial Complaint (Please check all that apply): **Court Ordered for Mental Health Services

Depressed Anxious Hyperactive/Distractible Academic Problem Addictions

Social Problems Behavioral Problems at Home and/or School Irritable/Angry/Oppositional

Meds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral (Please check all that apply):

Dissociative Behaviors Exaggerated Reactions Physical and verbal aggression

Detaching from Peers Tearful/despondent ”Dark” writings or drawings

Withdrawn Excessive daydreaming Anxiety Erratic

Change in personality Disruptive Anger Depression

Refusal to work/non-compliance Obsessive/Compulsive/perfectionist