REFERRAL FORM

PERSON REFERRING:		RELATIONSHIP TO CLIENT:	
AGENCY:		PHONE:	
CLIENT NAME:		ADDRESS CITY/ZIP CODE:	
CLIENT PHONE:		OKAY TO CALL/TEXT:	Y / N
CLIENT EMAIL:		OKAY TO EMAIL:	Y / N
DATE OF BIRTH:		AGE:	
SEX:		ORIENTATION:	
RELATIONSHIP STATUS:		IF YOUTH, PARENT NAME:	
INSURANCE:	Y / N	IF YOUTH, PARENT PHONE:	
INSURANCE TYPE:		INSURANCE NUMBER:	

PRESENTING PROBLEM:	PROGRAMS (CHECK ALL THAT APPLY)
	☐ INDIVIDUAL THERAPY ☐ FAMILY THERAPY ☐ COUPLES THERAPY ☐ ASSESSMENT ☐ A.R.T. ☐ ALTERNATIVE PARENT ☐ SOCIAL 101 ☐ ART THERAPY ☐ PLAY THERAPY ☐ BILINGUAL REQUEST

SYMPTOMS (CHECK ALL THAT APPLY)

☐ DEPRESSION	☐ ANGER	☐PERSONALITY CHANGES	☐ OTHER (DESCRIBE)
☐ ANXIETY	☐ SELF-ESTEEM	☐SCHOOL/WORK ISSUES	
☐ PANIC ATTACKS	☐ GREIF/LOSS	☐FAMILY ISSUES	
☐ ALCOHOL/DRUGS	☐ EATING ISSUES	☐RELATIONSHIP ISSUES	
☐ SUICIDAL	☐ MIXED MOODS	☐LEGAL ISSUES	
☐ SELF-HARM	☐ DEFIANCE	☐POOR SUPPORTS	

DIAGNOSIS	MEDICATIONS

CLIENT RELEASE

BY SIGNING, YOU ARE AUTHORIZING SERENTIY SHORES THERAPY CO. TO CONTACT AND SCHEDULE YOU FOR INTAKE OF THERAPEUTIC SERVICES.	CLIENT SIGNATURE	DATE