FOR OFFICE USE ONLY:
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LSJ COUNSELING AND CLINICAL SERVICES, LLC

1905 JN PEASE PLACE * SUITE 103 * CHARLOTTE, NC 28262 * OFFICE 704-910-0136 * FAX 866-800-2456

REFERRAL DATE:_____ **REFERRED BY:** _____

CLIENT NAME:_____ **CLIENT GENDER:**_____ **AGE:** _____

DOB:_____ **SOCIAL SECURITY #:**_____ **ETHNICITY:** _____

□ **BIOLOGICIAL PARENT** □ **LEGAL GUARDIAN (MUST PROVIDE LEGAL DOCUMENTS FOR VERIFICATION)**

PARENT/GUARDIAN NAME _____

PHONE (_____)_____ ALTERNATE PHONE: (_____) _____

EMERGENCY CONTACT _____

HOME PHONE (_____)_____ WORK HOME (_____) _____

ADDRESS_____CITY:_____STATE:_____ZIP:_____

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)

☐ COMPREHENSIVE ASSESSMENT ☐ FAMILY THERAPY ☐ GROUP THERAPY ☐ COUPLES THERAPY

☐ INDIVIDUAL THERAPY ☐ OTHER:_____

BRIEF DESCRIPTION OF PROBLEM (ATTACH SEPARATE SHEET IF NECESSARY. PLEASE FORWARD MEDICAL & BEHAVIORAL INFORMATION, COURT REPORTS, SOCIAL SUMMARIES, PREVIOUS EVALUATIONS, ETC.)

_____

_____

_____

_____

_____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

NAME OF INSURED_____POLICY # _____

DOES CLIENT HAVE ANY OTHER FORM OF INSURANCE? YES/NO

PLEASE FAX OR SCAN THIS COMPLETED FORM TO (866) 800-2456 OR ADMIN@LSJCOUNSELINGANDCLINICAL.COM