



INTAKE/REFERRAL FORM
 Rising Phoenix Health and Wellness
 Empowerment Center, LLC.
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REFERRAL SOURCE INFORMATION:

Date of Referral:	
Name and title of person making referral:	
Agency/Organization:	
Phone number:	
Email address:	
Are monthly reports needed once services begin? (Note: Release of Information Required)	<input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please provide receiving email address: _____
Is the client mandated to participate in services?	<input type="checkbox"/> YES <input type="checkbox"/> NO

CLIENT INFORMATION:

Client's Name:				Date of Birth:		
Age:		Gender:		Race		
Address:		City:		State:		Zip: _____
Phone Number:		Email Address:				
Insurance Type:		Policy Holder Name:		Policy #		
Parent/Guardian Name (If Applicable):						
Parent/Guardian Phone Number(s):						
Parent/Guardian Email Address:						

SERVICE(S) REQUESTED:

<input type="checkbox"/> Individual Therapy <input type="checkbox"/> Family Therapy <input type="checkbox"/> Group Therapy <input type="checkbox"/> Skills Building <input type="checkbox"/> Psychiatric Services <input type="checkbox"/> Other: _____

PRESENTING PROBLEM:

<input type="checkbox"/> ADHD <input type="checkbox"/> Anxiety <input type="checkbox"/> Behavioral Regulation <input type="checkbox"/> Defiance <input type="checkbox"/> Depression <input type="checkbox"/> DFCS Involvement <input type="checkbox"/> DJJ Involvement <input type="checkbox"/> Substance Use Disorder
<input type="checkbox"/> Family Conflict <input type="checkbox"/> Grief <input type="checkbox"/> History of Abuse/Trauma <input type="checkbox"/> History of Counseling <input type="checkbox"/> Life Changes <input type="checkbox"/> Stress Management
<input type="checkbox"/> Other: _____
Brief description of presenting problem:

ADMINISTRATIVE USE ONLY:

Referral received by:		Date received:	
Date processed:		Date of initial contact:	
Meets requirements for services:		Initial appointment scheduled for:	
Other notes:			