Client Referral Form

Date: _____

Client Information

Full Name: _____ Date of Birth: _____

Gender Identity: ☐ Male ☐ Female ☐ Non-binary ☐ Other ☐ Prefer not to say

Address: _____ Phone Number: _____

Email: _____

Emergency Contact Name & Relationship: _____

Emergency Contact Phone: _____

Presenting Concerns

What brings you in today? (Brief description)

_____

_____

Have you received mental health or substance abuse treatment before? ☐ Yes ☐ No

If yes, where and when?

_____

Primary concerns (check all that apply):
☐ Anxiety ☐ Depression ☐ Trauma ☐ Substance Use ☐ Stress ☐ Other:

_____

Medical & Psychiatric History

Do you have any diagnosed mental health conditions? ☐ Yes ☐ No
If yes, please specify:

_____

Are you currently taking any medications? ☐ Yes ☐ No
If yes, please list:

_____

Do you have any medical conditions? ☐ Yes ☐ No
If yes, please specify:

_____

Substance Use History

Substances used (check all that apply):
☐ Alcohol ☐ Marijuana ☐ Prescription Drugs ☐ Cocaine ☐ Opioids ☐ Other: _____

Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally

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Are you seeking help for substance use? ☐ Yes ☐ No

Social & Lifestyle Factors

Living situation: ☐ Alone ☐ With family ☐ With roommates ☐ Homeless

Employment status: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired

Do you have a support system? ☐ Yes ☐ No
If yes, describe:

_____

Goals for Treatment

What would you like to achieve through therapy or treatment?

_____

_____

Any specific areas of support or accommodation needed?

_____

_____

Consent & Acknowledgment

I understand that my information will be kept confidential and used to provide the best care possible.

Client Signature: _____

Date: _____