3966 Warrensville Ctr. Rd.
Warrensville Heights OH 44128
Phone: 440-340-5086
Fax: 440-340-5286
oh@restoreoutreachcenter.com

Intake/Referral Form

Demographic:

Date of Referral: _______________

Client Name: ____________________________________ DOB: __________ Age: ________

Grade: _______ Gender: _____________ Race: ____________ Ethnicity: _______________

Medicaid Number: __________________________ Health Plan: _______________________

Social Security Number: ______________________

Parent/Guardian Name: _________________________ Relationship: ___________________

Contact Information:

Phone Number: _______________________ Alternate Number: _______________________

Address: ____

City: _________________________ State: ________________ Zip Code: _______________

Education: Is this client enrolled in school:(YES / NO) School Name: _____________________

Presenting Problem(s): Please check all that apply

__Anxiety	__Criminal Behavior	__ Constant Restlessness	__Cutting Self	__Defiance
__Depression	__Destructiveness	__Difficulty Concentrating	__Fidgety	__Fighting
__Fire Setting	__Self Harm	__Hurting animals	__Lying	__Low Self Esteem
__Phobias	__Running Away	__Suicidal	__Temper Tantrums	__Verbal Threats

Past Treatment:

Has the client been diagnosed with a behavioral or mental disorder previously? _________
If "Yes", please explain? ____
Is client on any prescribed medication for this diagnosis? __________________________
Has the client been enrolled in any other agency/program? ________________________

Referral Source: ________________________________

Assessment appointment - Date: ________________________ at _____________________________

Name: ________________________ DOB: ________________ Medicaid No: ______________________