



Brittany Cephas, LCPC Mental Health Services, LLC

Client Referral from Parent/Guardian

Please print. Complete.

Date: _____

Child's Name: _____

Sibling(s)/Age: _____

DOB/Age: _____

Race: _____

Sex/Gender: _____

Name of School: _____

Teacher/Grade: _____

PERSONAL / SOCIAL / EMOTIONAL CONCERNS - Please select the areas of concern listed below.

Reason for Referral:

Anger Management

Yes _____

No

Family Conflict

Yes _____

No

Bullying Concerns

Yes _____

No

Negative Attitude

Yes _____

No

Social Skills

Yes _____

No

Self-Esteem

Yes _____

No

Low Motivation

Yes _____

No

Grief/Loss

Yes _____

No

ADD/ADHD

Yes _____

No

Worry/Anxiety

Yes _____

No

Marked Sadness

Yes

No

Please add additional information here:

ACADEMIC CONCERNS - Please tell us about your child's academics and attendance.

*** Attendance**

Yes _____

No

*** Underperforming/ Underachieving**

Yes _____

No

*** Follow Rules and Expectations**

Yes _____

No

Organizational Skills

Yes _____

No

FAMILY ISSUES - What are some concerns you have related to your child's behavior in your household.

Does your child have a hard time following household rules and expectations? If so, please explain:

Is your child respectful to family members? If not, please explain:

My child makes good choices at home. Please explain.

What else would you like us to know?

Date: _____

* Your Signature: _____

Email: _____

Phone: _____