Heal Together Counseling: Therapy Pre-Screener

Please send the completed form to:
rebecca@healtogethercounseling.com

This is a pre-screening tool to help determine if Heal Together Counseling would be a good fit for your child based upon their unique needs and the needs of your family. Once received, this will be reviewed, and a clinician will contact you about next steps.

Child's Full Name: _____ Date: _____

Age: _____ Gender (circle): Male Female Nonbinary Other

Insurance Provider:

Primary Insurance: _____

Secondary Insurance: _____

- If your child has NH Medicaid, please be sure to specify the MCO.
- If Heal Together Counseling is not in-network with your insurance, are you interested in private pay services? Yes No Unsure

Reason for Therapy (circle all that apply):

Behavioral Issues	Attention Issues	Emotional Regulation
Aggression/Violence	Trauma	Abuse/Neglect
Family Separation	School Issues	Anxiety/worry
Covid-19 concerns	Military Family Issues	Drugs/Alcohol
Court Ordered/Legal	Complex Medical	Difficulty Adjusting
ADHD	Depression	Divorce/Separation
Autism	Social/Peer Issues	Family Issues

Other: _____

Has therapy been recommended by other providers? Yes No

Mental Health History:

Is your child receiving any of the following (circle all that apply): OT PT Speech

Is your child receiving any other services? No Yes, _____

Please list any current diagnosis that your child has received:

_____

Contact Information:

Parent/Guardian's Name: _____

Phone: _____

Email: _____

Interested Services (circle all that apply):

Child Therapy Parent Coaching Educational Advocacy

Scheduling Availability (circle all that apply):

Any (Flexible Schedule): Mornings Afternoons Evenings

Referred By:

Name/Facility: _____

Are you currently working with this provider? Yes No