



NEW CLIENT REFERRAL FORM

Date of Referral: _____ Referral Source: _____

Referral Source Phone: _____ Fax: _____

Referral Source Email: _____

CLIENT INFORMATION

Client Name: _____ Male Female

Client Legal Guardian (if minor): _____

Client Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Summary of Prior record if applicable: (attach a sheet if needed)

Have you ever been charged with or convicted of arson or a sex crime? YES ___ NO ___

History of substance abuse? (specify & explain)

Any history of mental health issues, diagnoses or medication? (Specify & explain)

10. How is your general health?

Good _____ Fair _____ Poor _____

11. Briefly describe any health or medical issues:

12. Is the client taking any medications? If so, list:

INSURANCE INFORMATION

* a copy of the front and back of the insurance card is required*

Primary Insurance: _____

Customer Service Number: _____

Identification Number: _____

Name of Policyholder: _____

Relationship to Client: _____ DOB of policyholder: _____

SS# of policyholder: _____ Employer: _____