4014 Greenleaf St. Indian Trail, NC 28079 Tel: (704)-774-1956 Fax: (866)-706-1632

DATE ________________

REFERRAL SOURCE (AGENCY/PERSON) ____

ADDRESS ____ PHONE (_____)__________

FAX NUMBER _(____)________________________ EMAIL ADDRESS______________________________________

CLIENT'S NAME ____ DOB ________________

SOC. SEC. # ___________________ GENDER ________ AGE ______ RACE ___________ ETHNICITY ___________

IF CHILD, HAS CHILD BEEN IN SCHOOL WITHIN THE LAST 3 MONTHS? YES/NO WHAT IS CURRENT OR HIGHEST GRADE COMPLETED? ______

IF ADULT, WHAT IS THE HIGHEST GRADE COMPLETED? ________ HAS CLIENT BEEN ARRESTED IN LAST 30 DAYS? YES/NO # OF TIMES___

ADDRESS ____

HOME PHONE (_______) __________________ WORK HOME (_________) _________________________

□ **BIOLOGICIAL PARENT** □ **LEGAL GUARDIAN (MUST PROVIDE LEGAL DOCUMENTS FOR VERIFICATION)**

PARENT/GUARDIAN/OTHER ____

HOME PHONE (_______) __________________ WORK HOME (_________) ______________________________

EMERGENCY CONTACT ____

HOME PHONE (_______) __________________ WORK HOME (_________) ______________________________

ATTORNEY (IF APPLICABLE) ____

ADDRESS ____ OFFICE PHONE (______) ______________________

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)

□ THERAPEUTIC MENTORING	□ PARENT SUPPORT	□ INDIVIDUAL THERAPY	□ FAMILY THERAPY
□ COUPLES THERAPY	□ MARITAL THERAPY	□ GROUP THERAPY	□ DIAGNOSTIC EVALUATION
□ TESTING	□ LIFE COACHING	□ CLINICAL SUPERVISION	□ IN-HOME THERAPY

BRIEF DESCRIPTION OF PROBLEM (ATTACH SEPARATE SHEET IF NECESSARY. PLEASE FORWARD MEDICAL & BEHAVIORAL INFORMATION, COURT REPORTS, SOCIAL SUMMARIES, PREVIOUS EVALUATIONS, ETC.)

____

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Concerns/Needs to be addressed in therapy: (please check all that apply)

___Hyperactivity
___Hoarding
___Abuse/Neglect
___Hallucinations
___Obsessive Compulsive Disorder
___Bipolar Disorder
___Social/peer Issues
___Codependency
___Attention Concerns
___Memory Concerns
___Body Image Issues
___Low Self Esteem
___Legal/DSS Involvement
___Recent divorce/separation
___Relationship concerns
___Chronic Pain
___Anxiety
___Recent trauma
___Substance Abuse
___Academic Problems
___Self-harm behaviors
___Grief/Loss
___Sleep/eating concerns
___Domestic Violence
___Panic Symptoms
___Behavioral Issues
___Depressed Mood
___Employment Problems
___Victim of Bullying
___Mood Disorders
___Anger Management
___PTSD

BILLING INFORMATION

Primary insurance company ____

POLICY # ____________________ AUTHORIZATION # ________________ PHONE (_____) __________
NAME OF INSURED ______________________________ DOB: __________________________________
POLICY HOLDER_________________________________ DOB:__________________________________
ADDRESS (IF DIFFERENT FROM ABOVE):____
____

DOES CLIENT HAVE ANY OTHER FORM OF INSURANCE? YES/NO

Secondary insurance company ____

POLICY # ____________________ AUTHORIZATION # ________________ PHONE (_____) __________
NAME OF INSURED ______________________________ DOB: __________________________________
POLICY HOLDER_________________________________ DOB:__________________________________
ADDRESS (IF DIFFERENT FROM ABOVE):____
____

Preferences for Appointment Times: ___ Mornings ___ Afternoons ___ Evenings

___ Mon ___ Tues ___ Wed ___ Th ___ Fri

Comments about Preferences ____

Other Preferences: ____

PLEASE FAX THIS COMPLETED FORM TO: (866)-706-1632 OR

MAIL TO: 4014 GREENLEAF ST. INDIAN TRAIL, NC 28079