DATE OF 1st CALL: Appointment Date:

Person Completing Form:

Strive Counseling Services, L.L.C

Referral Form for Mental Health Services

Client Information

		•						
Name:	Date of Birth:		Race/Ethnicity:					
Partner Name:		Date of Birth:	Race/Ethnicity:					
Gender: Male Female	☐Couple ☐Individual	School & Grade:	Email Address:					
Gender. Bywaie Bremaie	Becopie Bindividual	school & Oldde.	Email Address.					
Services Requested: Office-B	ased Outpatient Teleh	eath						
Service Location: Downtown Office Home School (if, applicable)								
CONTACT NUMBERS: PARTNER CONTACT NUMBERS:			Message ok? Tyes No					
ADDRESS:								
	-							
Parent or Legal Guardian	Information:							
Name of Parent, Legal Guardia	n or Insured:	Address:	Phone Number					
Contact Numbers: Type of settir	ng: Home Group Home	☐ Foster Home ☐ Ps	sychiatric hospital Other					
Payment Information:		•						
Type of Insurance Medicaid	(DHR) BCBS Dother							
Insurance ID or Contract#		GROUP#						
Effective Date: Type of Insurance: Insurance ID or Contract# Secondary Insurance ID or Contract# Referral Source Information: Complete this section s		Insurance Phone to ve	rify benefits #					
Referral Source Informatio	n: Complete this section so w	e can contact you after t	the referral is made.					
Name:		Email:						
Phone #								
Phone#								
How did you hear about Strive (Counseling?							
Child/Adult Mental Health	Information:							
Current medication & dosage		Current DSM-IV Diagno	osis					

Prescribing Physician name & Phone							
Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe		
Hallucinations (describe)							
Delusions							
Thought disorder							
Bizarre (psychotic) behavior (describe below)							
Anxiety / Nervousness							
Obsessive / compulsive							
Phobias / fears							
Depressed mood							
Mood swings							
Sleep disturbance							
Irritability							
Anger / temper tantrums							
Hyperactivity							
Attention deficit							
Eating problems							
Elimination problems							
Oppositional / defiant to those in authority							
Antisocial / delinquent behavior / conduct disorder							
Over sexualized behavior							
Somatic complaints with no known medical cause							
Attachment disorder (explain below)							
Other (explain)							

Additional Comments

Been in counseling before?:

Availability Revised 01/2023