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:
Services Requested: ❒ Office-Based Outpatient ❒ Teleheath		
Service Location: ❒ Downtown Office ❒ Home ❒ School (if, applicable)		
CONTACT NUMBERS:	**PARTNER CONTACT NUMBERS:**	Message ok? ❒ Yes ❒ No
ADDRESS:		

Parent or Legal Guardian Information:

Name of Parent, Legal Guardian or Insured:	Address:	Phone Number
Contact Numbers: Type of setting: ❒ Home ❒ Group Home ❒ Foster Home ❒ Psychiatric hospital ❒ Other		

Payment Information:

Type of Insurance ❒ Medicaid (DHR) ❒ BCBS ❒ Other	
Effective Date:	Type of Insurance:
Insurance ID or Contract#	GROUP#
Secondary Insurance ID or Contract#	Insurance Phone to verify benefits #

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name:	Email:
Phone#	
How did you hear about Strive Counseling?	

Child/Adult Mental Health Information:

Current medication & dosage	Current DSM-IV Diagnosis

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)					

Reason for referral for treatment: In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting.

Additional Comments

Been in counseling before?:

Availability Revised 01/2023