I DO CARE COUNSELING & CONSULTING SERVICES, PLLC

CLIENT REFERRAL FORM

Name:_____ Date: _____

Address: _____

Home Phone: ___ _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No **Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: _____ Age: _____ Gender: _____

Martial Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Referred By (if any): _____

Reason for Referral_____

_____

Case/Auth. Info (if any): _____

CLEINT HISTORY:

Have you previously received any type of mental health services?
□ No □ Yes, How Long Ago? _____

Are you currently experiencing thoughts to harm yourself or others? □ No □ Yes

Are you expecting/experiencing any significant life changes? _____
_____
_____
_____

DSS/Court Involvement Yes ☐ No ☐

Legal Issues/Criminal Yes ☐ No ☐

Substance Abuse History Yes ☐ No ☐