COVENANT COUNSELING & CONSULTATION SERVICES

INTAKE/ REFERRAL FORM

Which services are you seeking at this time?

❒ Intensive In-Home	❒ Parenting Capacity Assessment	❒ A&D Assessment
❒ Outpatient	❒ Anger Management	❒ A&D Treatment
❒ Individual Counseling	❒ Group Counseling	❒ Family Visitation
❒ Other Mental Health Services	❒ Homemaker	❒ Prevention & Diversion CM
❒ Family Support & Care Coor.	❒ MH Case Mgt/Psychotherapy	❒ Sitter

Contact Information: **Date of Referral:**_____

Client Name:_____

Address: _____

City/State_____ **Zip Code**_____

Phone: _____ **Cell:** _____

Fax: _____ **Email:** _____

Date of Birth: ____/_____/_____ **SSN:** _____-_____-_____ **Gender: Male** _____ **Female** _____

Race:

____**African-American** ____**Asian** ____**Caucasian** ____**Latino** ____**Native-American** ____**Other**

Legal Status: Citizen: Yes ____ ***No*** ____ ***Custody Status:*** _____

Insurance type: _____

Parent /Guardian/Spouse (if applicable):

_____

Emergency Contact:

Address: _____

City/State_____ **Zip Code**_____

Phone: _____ **Cell:** _____

Fax: _____ **Email:** _____

Person Making Referral: _____

Phone: _____ **Cell:** _____

Fax: _____ **Email:** _____

Relation to Client:_____

*****Does the family know you have referred them for services?*****

Yes____ No____

History of Treatment

Please list any diagnosis and code:

_____

_____

List any medication/s you are currently taking or should be taking:

_____

_____

List any medication/s you have been prescribed in the past:

_____

_____

Presenting Problem/s: (Circle all that apply and give brief description – use additional sheet if needed)

Alcohol/Drug Use * Drop in Grades * Loss of Job * Divorce/Separation * Truancy * Physical/Sexual/Emotional Aggression * Violation of Curfew * Legal Issues, etc.

_____

_____

_____

_____

_____

Has the client experienced recent or history of trauma that might have contributed to the above behaviors? (*death of a loved one, divorce/break-up, sexual molestation, etc.)*

_____

_____

_____

_____

_____

_____

The above information is true to the best of my knowledge. I understand I am responsible for payment of services to be paid directly to my counselor. I understand if I need to cancel an appointment I must do so 24 hours prior, if not I am financially responsible for the missed session. I also understand that if I pay by check I am responsible for any non-sufficient fund fees.

Client/Agency Representative Signature: _____

Therapist Signature: _____

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