Intake/Referral Form

Date: _____ Referral Source: _____ Phone #:_____

Referral For: ☐ **Anger Group** ☐ **Self Esteem Group** ☐ **Parenting group** ☐ **Stress Mgmt Group**
☐ **Depression Group** ☐ **Individual Counseling** ☐ **Assessment** ☐ **Pre-Marital Counseling**
☐ **Christian Counseling** ☐ **Group Counseling** ☐ **Other:** _____

Client Name: _____ ☐Male ☐Female Phone #:_____

Client's Parent/Legal Guardian: _____ Work #:_____

School Child Attends: _____ Grade: _____

Client Address: _____ County: _____

DOB: _____ Age:_____ Race:_____ Martial Status:_____

Name of Spouse/Significant Other: _____

Type of Insurance: Medicaid _____ NC Health Choice ____ None (Private Pay) _____

MID/Insurance Group# _____ Verified by: _____

Reason for Referral:

☐ -Aggressive Behavior
☐ -Changes in sleep patterns
☐ -Desire to hurt self/others
☐ -Feeling worthless
☐ -Hoarding
☐ -Loss of interest
☐ -Multiple physical/ health complaints
☐ -Pacing/restlessness
☐ -Relationship problems
☐ -other:_____

☐ -Angry Outbursts
☐ -Crying spells/tearfulness
☐ -Excessive daytime sleeping
☐ -Hallucinations
☐ -Hollering/yelling/screaming
☐ -Low energy or fatigue
☐ -Multiple disruptions in school
☐ -Poor concentration
☐ -Verbal aggression
☐ -other: _____

☐ -Changes in appetite
☐ -Decline in personal hygiene
☐ -Feeling hopeless
☐ -Hitting/spitting/throwing objects
☐ -Irritability
☐ -Mood swings
☐ -Nightmares
☐ -Social withdrawal/Isolation
☐ -Excessive Worrying
☐ -other: _____

Please describe desired outcome/Other Comments:

_____

_____

_____

_____

_____

Completed by: _____ Date:_____

Fax to 877-316-3082 or email to npatterson@theseedplanter.net