**Date:\_\_\_\_\_\_\_\_**

**Type of Service Requested** In-School Counseling  In-Home Counseling In-Office Counseling

**Referral Source Information (If not parent/client making referral)**

Person Making Referral: ­­­­­­­­­­­­­\_\_\_\_\_\_\_ \_\_\_\_\_\_\_Relationship/Agency: \_\_

Contact Information-Address: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Telephone #: \_\_\_\_ \_\_\_\_\_ Email: \_\_\_\_ \_\_\_

**Client/Family Information**

Client Name: SS#: \_

Address: \_\_ \_\_\_\_\_  
  
DOB:\_\_ \_\_\_ Age: \_\_\_\_ Gender: \_\_\_ Language: English Spanish Creole Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # (home): \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ (other): \_\_\_\_\_\_\_\_\_\_\_

School Name: \_\_\_\_ \_\_\_ Grade: \_ \_ Education:  SED  EH  SLD  EMH  TMH  VE

**If client is a minor, who has authority to consent to treatment?**

Name: \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child:  Parent  Relative  Foster Parent  Case Manager Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client’s Presenting Issues**

Current Psychotropic Medications **N** **Y**

Referral Concerns:

Client Mental Health / Substance Abuse History **N** **Y ATTACH CBHA if available:** **N** **Y**

Currently Receiving Counseling services? **N** **Y** If yes, what type and where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Clinician Use only***

Client Eligible for Services: Yes  No

Level of Need:  Emergent (Life Threatening)  Urgent  Routine  Court Ordered

History of DV in the Home? Yes  No

Are there dog(s) in the home? Yes  No

Date Intake Appointment is Offered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Scheduled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_