



ART OF AWARENESS

NEW CLIENT REFERRAL FORM

Today's Date:

Name: _____ DOB: _____ Age: _____ Gender: _____

Address: _____

CellPhone: _____ Home Phone: _____ Work Phone: _____ OK to leave a message at: _____

Insurance Carrier: _____ Insurance I. D. #: _____

Insurance Phone # for Mental/Behavioral Health Providers: _____

If you have a 2nd Insurance, please list carrier name, phone and ID#:

Relational Status: _____ Are you a student: _____ School/Grade: _____

Employment Status: _____ Occupation: _____

Emergency Contact Name & Number: _____

Do you have a partner, family member or close friend who is currently working with an Art of Awareness therapist?

If yes, please list:

Do you have allergies? _____ If yes, please list: _____

Do you have a Primary Care Provider? _____ PCP name and practice: _____

Are you currently working with any other medical providers/healthcare professionals (e.g. nutritionist, acupuncture, medical specialists)? _____ If Y, please list: _____

We occasionally have a dog in our building. Would that be a problem for you?

How did you find out about us?

Are you currently seeing a therapist? _____ Current Therapist Name: _____

Have you sought therapy in the past ? _____ Past Therapist Name: _____ Dates Seen: _____

Please describe the issues you want to address in therapy (REQUIRED):

Therapist Preference: Male Female Either/not important

What days & times can you meet with us?

The following questions may or may not apply to you. We ask every new client these questions. Please answer them to the best of your ability.

Have you ever been hospitalized for a Mental Health, Substance Abuse or an Eating Disorder related concern?

If yes, when and where?

Are you currently taking medications?

If Y, please list:

Are you currently experiencing any of the following? :

Poor Sleep:

Change in Appetite:

Medical Health Problems: if Y, please list:

Have you experienced any the following currently or in the past? :

NOTE: If you are currently in crisis related to any safety issues, please do not wait to hear back from us before getting help. Call 911 or the Crisis Line at (888) 568-1112.

Thoughts of Suicide or Self Harm	Current	Past	Never/ Not Applicable
Suicidal Intent/Plan	Current	Past	Never/ Not Applicable
Thoughts of harming anyone	Current	Past	Never/ Not Applicable
Homicidal Plan/ Intent	Current	Past	Never/ Not Applicable
How much alcohol do you drink on a weekly basis?			
Do you abuse or over use any drugs?	Current	Past	Never/ Not Applicable
Have you experienced any traumatic events?	Current	Past	Never/ Not Applicable
Do you have a family history of mental health, substance abuse, or eating disorders?			
Do you have Disordered Eating?	Current	Past	Never/ Not Applicable

Resources and Support:

What activities do you enjoy?

Who is in your current support system?

What are your strengths?

For office use

Therapist referred to:

Ind. Tx.____, Group .____, Family _____, or IOP _____