ART OF AWARENESS

NEW CLIENT REFERRAL FORM

Today's Date:

Name: DOB: Age: Gender Identity:

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/Relationship & Number:

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

If yes, therapist's name and partner/family member/friend's name:

Do you have allergies? If yes, please list:

Do you have aPrimary Care Provide? 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?

100 WATERMAN DRIVE, SOUTH PORTLAND, MAINE 04106

PHONE: 207-799-1331 FAX: 207-799-1350 EMAIL: clientservices.aoa@gmail.com

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_____

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