ART OF AWARENESS

100 Waterman Drive Suite 201 South Portland, ME 04106
Phone: 207-799-1331, Fax: 207-799-1350, EMAIL: clientservices.aoa@hushmail.com

NEW CLIENT REFERRAL FORM

Today's Date:

Name (Chosen Name): DOB (mm/dd/yy):

Name (Legal Name): Gender Identity: Pronouns:

Mailing Address:

Phone: Is it okay to leave you voicemails? Email:

Subscriber Name on Insurance Policy:

Insurance Carrier: Is this a Medicare Policy?

Insurance I.D. #: PH# for Provider Services:

If you have a 2nd Insurance please list Carrier Name, I.D. #, and PH# for Provider Services:

*Please note: We do not accept Mainecare or Medicaid

Relational Status: Are you a Student? School/Grade:

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

If so, please provide the name of the therapist & partner/friend/family member's name:

Are you employed? Where do you work?

Emergency Contact Name, Relation, and PH#:

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

Do you have a PCP? PCP Name & Practice:

Are you currently working with any other healthcare providers (e.g. nutritionist, psychiatrist, medical specialists)?

Please list their Name & Profession:

How did you find out about Art of Awareness?

Are you currently seeing a therapist? Current Therapist's Name:

If Yes, are you looking to switch individual therapists?

Have you sought therapy in the past? Past Therapist's Name:

Are you interested in Telehealth Counseling Services?

Topics to be addressed in therapy (REQUIRED):

Therapist Preference: Male_☐_ Female_☐_ Either/Not Important_☐_

What type(s) of therapy service(s) are you seeking (Individual, Couples, Family, Group, Intensive Outpatient Therapy)?

What days and times would work best for you to come meet with us (REQUIRED)?

ART OF AWARENESS
100 Waterman Drive Suite 201 South Portland, ME 04106
Phone: 207-799-1331, Fax: 207-799-1350, EMAIL: clientservices.aoa@hushmail.com

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

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

Y ☐ N ☐ If Yes, please list when and where:

Are you currently taking medications? Y ☐ N ☐ If Yes, please list:

Are you currently experiencing any of the following?

Poor Sleep	Y ☐	N ☐	
Change in Appetite	Y ☐	N ☐	
Medical Health Problems	Y ☐	N ☐	If Yes, please list:

Have you experienced any of the following currently or in the past? **(Crisis Line 24/7 PH# 888-568-1112)**

Thoughts of Suicide or Self Harm	☐ Current	☐ Past	☐ Never/Not Applicable
Suicidal Intent or Plan	☐ Current	☐ Past	☐ Never/Not Applicable
Thoughts of harming another person	☐ Current	☐ Past	☐ Never/Not Applicable
Homicidal Intent or Plan	☐ 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 use disorder, or eating disorders?			☐ Y ☐ N
Do you have Disordered Eating?	☐ Current	☐ Past	☐ Never/Not Applicable

Resources & Support:

What activities do you enjoy?

Who is in your current support system?

What are your strengths?