ART OF AWARENESS

100 Waterman Drive Suite 201 South Portland, ME 04106
Phone: 207-799-1331, Fax: 207-799-1350, Email: clientservices@artofawareness.org
Send Intensive Outpatient Program Referrals to: iop@artofawareness.org

**NEW CLIENT REFERRAL FORM**

Today's Date:

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

Legal Name (If Different): 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:

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/First Available__☐__

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

**Which days and times would work best for you to meet with one of our Clinicians (REQUIRED)?**

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*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 Self Harm | ☐ Current | ☐ Past | ☐ Never/Not Applicable |
| Thoughts of Suicide | ☐ Current | ☐ Past | ☐ Never/Not Applicable |
| Suicidal Intent or Plan | ☐ Current | ☐ Past | ☐ Never/Not Applicable |
| Thoughts of physically harming another person | ☐ Current | ☐ Past | ☐ Never/Not Applicable |
| Homicidal Intent or Plan | ☐ Current | ☐ Past | ☐ Never/Not Applicable |

**If you answered "yes/current" to the above questions, please reach out to the crisis line (888-568-1112) or go to your nearest emergency room. Art of Awareness is not a crisis program, we are a by appointment only Therapy Practice and Intensive Outpatient Program. We will get back to you within 72 business hours upon receipt of your New Client Referral. Please reach out to the crisis line if you are in need of immediate support.**

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 |

**Overall, on a scale of 1 to 5, to what degree are the symptoms you are experiencing affecting your daily life & functioning?**

(1 being not at all, 5 being severely impacting your daily life): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

**Resources & Support:**

What activities do you enjoy?

Who is in your current support system?

What are your strengths?