Center for
Safety & Healing
COMPASSION | HOPE | RESILIENCE

Client Referral Form

Name:_____
Date of Birth:_____
Gender Identification:_____
Phone Number:_____
Email: _____
Address:
_____

Parent/Legal Guardian name: _____
Parent/Legal Guardian phone number: _____
Parent/Legal Guardian email: _____
Parent/Legal Guardian address: _____

Case Manger name: _____
Case Manger number: _____
Case Manger email: _____
Case Manger address: _____

Reason for Seeking Services:

1. Briefly describe the primary concern or reason for seeking mental health services:

_____
_____
_____

2. What treatment services are you interested in:
   _____ Individual Therapy
   _____ Family Therapy
   _____ Group Therapy
   _____ Intensive Outpatient Therapy Program (IOP) (Group or Individual)
   _____ Therapy Intensive
   _____ Evaluation:_____
   _____ Other:_____

Current Symptoms:

1. Please describe any symptoms or issues you are currently experiencing (e.g., mood changes, anxiety, sleep disturbances):

_____
_____
_____
_____
_____

Checklist of Symptoms for Mental Health Assessment (check all that apply):

Depression:
_____ Persistent sadness or low mood
_____ Loss of interest or pleasure in activities once enjoyed
_____ Changes in appetite or weight
_____ Insomnia or excessive sleeping
_____ Fatigue or loss of energy
_____ Feelings of worthlessness or excessive guilt
_____ Difficulty concentrating or making decisions
_____ Thoughts of death or suicide

Anxiety:
_____ Excessive worry or anxiety most days
_____ Restlessness or feeling on edge
_____ Fatigue
_____ Difficulty concentrating or mind going blank
_____ Irritability
_____ Muscle tension
_____ Sleep disturbances (difficulty falling asleep, staying asleep, or restless sleep)
_____ Panic attacks (sudden onset of intense fear or discomfort, chest pain, rapid heartbeat, sweating, shaking)

Mood
_____ Periods of unusually elevated mood (mania)
_____ Increased energy, activity, or agitation
_____ Decreased need for sleep
_____ Grandiosity or inflated self-esteem
_____ Racing thoughts or fast speech
_____ Impulsivity or risky behaviors
_____ Periods of depression alternating with manic episodes

Post-Traumatic Stress Responses:
_____ Intrusive memories or flashbacks of a traumatic event
_____ Avoidance of reminders of the trauma
_____ Negative changes in thoughts and mood
_____ Hyperarousal (being easily startled, feeling tense or on edge)

_____ Difficulty concentrating
_____ Sleep disturbances

Obsessive-Compulsive Behaviors:
_____ Obsessions (persistent and unwanted thoughts, urges, or images)
_____ Compulsions (repetitive behaviors or mental acts)
_____ Attempts to ignore or suppress obsessions
_____ Significant distress or impairment in daily functioning due to obsessions or compulsions

Psychosis:
- Hallucinations (seeing, hearing, or feeling things that others do not)
- Delusions (fixed, false beliefs not based in reality)
- Disorganized thinking (speech that is difficult to follow)
- Disorganized or abnormal motor behavior (e.g., catatonia)
- Negative symptoms (reduced ability to initiate and sustain activities, diminished emotional expression)

Distorted eating/body behaviors:
- Preoccupation with body weight, shape, or appearance
- Restricting food intake or excessive dieting
- Binge eating episodes (eating large amounts of food in a short period)
- Compensatory behaviors (purging, excessive exercise)
- Distorted body image
- Fear of gaining weight

Substance Use:
- Taking the substance in larger amounts or for longer than intended
- Persistent desire or unsuccessful efforts to cut down or control substance use
- Spending a lot of time obtaining, using, or recovering from substance use
- Cravings or strong urges to use the substance
- Continued use despite knowing it is causing problems in relationships or health

Personality:
- Persistent patterns of behavior and inner experience that deviate markedly from the expectations of the individual's culture
- Impairment in interpersonal functioning, self-image, and emotions
- Patterns are inflexible and pervasive across a broad range of personal and social situations

Psychiatric History:
1. Has the youth ever been diagnosed with a psychiatric disorder? If yes, please list:

Medical History:

1. Has the youth had any significant medical conditions? If yes, please list:

Medication History:

1. Is the youth currently taking any medications? If yes, please list:

Substance Use:

1. Does the youth use or have a history of using substances (e.g., alcohol, drugs)? If yes, please describe:

Family History:

1. Are there any psychiatric disorders or significant mental health issues in the youth's family? If yes, please specify:

2. Any family history of suicide or self-harm? If yes, please specify:

Educational/Work History:

1. What is youth current occupation or level of education? What school do they current attend?

Support System:

1. Who are the youth's main sources of support (e.g., family, friends, significant others)?

Strengths and Interests:

1. What are the youth's strengths?

2. What interests does the youth have?

Previous Therapy/Counseling:

1. Has the youth received therapy or counseling before? If yes, please describe:

2. Has the youth participated in any residential treatment or previous hospitalization for mental health issues? If yes, please describe:

Goals for Therapy:

1. What goals or expectations do you or the youth have for therapy?

Additional Information:
Is there any other information you believe is important for your therapist to know?