S.T.E.P. into Wellness
Striving Towards Endless Possibilities

CLIENT REFERRAL FORM

Date: _____/______/_______

Agency/Organization/Individual Referral Information
Name: ____
Relationship to potential client: _____________________
Primary Phone (s): ___________________________ Referred by: ____________________________________

Client Information
Full Name: ____ Gender: ☐ M ☐ F
D.O.B.: ____________ Age: _______
Phone numbers: (H)________________________ (C) _________________________
Home Address: ____
City: ____________________State: ___________ Zip Code: ___________________

Parents/Legal Guardian Information
Mother's Name: ____
Father's Name: ____
Phone numbers: (H)________________________ (C) _________________________
☐ Parents married or living together ☐ Parents are divorced ☐ Parents are separated
☐ Divorce final and no court proceedings scheduled
☐ Current custody/visitation issues pending resolution in court
☐ Foster child
**In cases of divorce and separated parents, S.T.E.P. into Wellness, LLC clinicians will request the most recent custody and/or visitation orders (including separation agreements) prior to starting services in order to clarify the current status of physical and legal custody.*

Languages Spoken by Client: ______________________________________

Treatment/Therapy
☐ Individual Therapy ☐ Couples Counseling/Therapy ☐ Family Therapy
☐ Other ____

Are services court ordered? ☐ Yes ☐ No
If Yes, please indicate reason for Court Involvement:
☐ ____

Appointment Preferences
(This does not guarantee your appointment will be on the day/time that you select).
Preferred days of week: M___T___W___Th___Fr__Sat____ (please select at least two possible days)

Time of Day: AM___ PM____ Preferred Times: _____________________

If you are a parent, would childcare services be beneficial for you during your sessions? ______

S.T.E.P. into Wellness
Striving Towards Endless Possibilities

General Problem Area

☐ Depression ☐ Low Self-esteem ☐ School Issues
☐ Mood or Anxiety ☐ Parenting Problems ☐ History of Childhood Trauma
☐ Behavior Problems ☐ Marriage/Relationship Issues ☐ Physical Abuse/Neglect
☐ Other: ____

Specific Areas of Concern

☐ Abandonment ☐ Coping Skills ☐ Obsessive/Compulsive
☐ Academic Concerns ☐ Depressed ☐ Oppositional/Defiant
☐ Aggression/Anger ☐ Family Conflict ☐ Quality of Thinking
☐ Anxiety ☐ Grief ☐ Self Esteem Issues
☐ Argumentative ☐ Hallucinations ☐ Self Harm
☐ Avoidance of People/Places ☐ Homicidal Ideation ☐ Sleeping
☐ Behavior Issues ☐ Hyperactivity ☐ Social Skills
☐ Bullying ☐ Impulsivity ☐ Suicidal Ideation
☐ Communication ☐ Irritable ☐ Excessive Worrying
☐ Other ____

Previous Mental Health Intervention or Services

Has client previously received mental health services? ☐ Yes ☐ No
If Yes, please indicate most recent provider/agency/location:
____
Is client currently taking medication? ☐ Yes ☐ No
Name of medication(s): ____

Reason for taking medication(s): ____

Funding Source

☐ Self-Pay
☐ Credit card/debit card authorization form signed
☐ Insurance
☐ Out of network insurance reimbursement will be requested

To submit this referral form to S.T.E.P. into Wellness, you may print and send via fax: ___________
Email submissions are accepted if the sender is the client or client's legal guardian or legal representative. With this option, you are granting consent to the above information being transmitted by way of electronic communication to be reviewed by S.T.E.P. into Wellness Owner, Barbara Stephenson. Once received, this information is included as Protected Health Information (PHI) in the medical record should a service be agreed upon. If no service is initiated, this form with your information will be shredded. If you have any questions, please call our main line at 703-334-2206.

FOR INTERNAL USE:
Referral assigned to:_______________________________ Assignment Date:_________
☐ This form was reviewed for screening and assignment by Barbara Stephenson, LMFT