

Women Children and Family Counseling Referral

Date of referral: _____

Referral Source: _____ Referral Phone # _____ Referral email _____

Male Female Married Divorced Single Prefer not to answer

Client Name: _____ Client DOB: _____

LEGAL Guardian: _____ Guardian Phone# _____

Client/Guardian Email Address: _____

Client Address: _____

Foster Parent: _____ Foster Parent Phone # _____

Emergency Contact _____ Relationship: _____ Phone# _____

Primary Care Physician: _____ Phone#: _____

Address: _____ City: _____ Zip: _____

School attending: _____

INSURANCE INFORMATION

Primary Insurance:	Insurance ID #:
Policy Holder Name:	Medical Record #
Secondary Insurance:	Secondary Insurance #:

CLIENT HISTORY

Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No	Risk/Needs:
Presenting Problem:	

Women Children and Family Counseling Services
704 S Garnett Street, Henderson NC 27536
252-395-5185 Fax 888-965-1168