

Resiliency Center

Adult Referral (#__ of __)

Date: _____

Client Information:

Name: _____ Phone: _____

DOB/Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

☐ Text ☐ Call ☐ Email

Best time to call: _____

Email address: _____

School: _____ Work: _____

Preferred Pronouns: _____

Ethnicity: _____ Primary Language: _____

Insurance Information:

Medi-Cal: ☐ Cal-Viva ☐ Anthem ☐ EAP ☐ Private insurance ☐ Private Pay

ID #: _____ Other: _____

Availability/Preferences:

Preferred Day of Appointment: ☐ M ☐ T ☐ W ☐ TH ☐ F Preferred Time: _____

Gender Preference for Therapist: ☐ Male ☐ Female ☐ Either

Session Preference: ☐ Telehealth ☐ In Person ☐ Either

Transportation ☐ Yes ☐ No

Have you previously had therapy? ☐ Yes ☐ No

If yes, provide diagnosis? _____

Do you take psychiatric medication (s)? ☐ Yes ☐ No

Which medication (s)? _____

Areas of Concern/Risk:

☐ Suicide ideation ☐ Self-harm ☐ Trauma ☐ Grief/Loss ☐ Domestic Violence ☐ Human Trafficking

Please briefly describe presenting concerns: _____

Do you have a safety plan? ☐ Yes ☐ No Restraining Order: ☐ Yes ☐ No

Fees for service:

Student Intern: \$40 Registered Associate Therapist: \$80 Licensed Therapist: \$120

Referral Source:

Name: _____ Agency: _____

Phone Number: _____ Email Address: _____