DATE OF 1st CALL: **Person Completing Form:**

Strive Counseling Services, L.L.C.
Crystal Mullen-Johnson, LICSW, PIP, RPT

Referral Form for Mental Health Services

Client Information

Name:	Date of Birth:	Race/Ethnicity:
Gender: ❒ Male ❒ Female ❒ Couple	School & Grade:	
Email address:		
Service Location: ❒ Downtown Office ❒ Home ❒ School (if, applicable)		
CONTACT NUMBERS:	Message ok? ❒ Yes ❒ No	
ADDRESS:		

Parent or Legal Guardian Information:

Name of Parent or Legal Guardian:	Address:
Contact Numbers:	Type of setting: ❒ Home ❒ Group Home ❒ Foster Home ❒ Psychiatric hospital ❒ Other

Payment Information:

Type of Insurance ❒ (DHR) ❒ BCBS ❒ Other	GROUP#
Insurance ID/ Contract Number:	Effective Date:
Member address:	Employer:
Member Name:	Contact Number:
Member Address:	D.O.B:

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name	Mailing Address
Phone#	Email address
How did you hear about Strive Counseling Services?	

Child/Adult Mental Health Information:

Current medication & dosage	Current DSM-IV Diagnosis
Prescribing Physician Name & Phone	

Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe

Hallucinations (describe)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Oppositional / defiant to those in authority					
Antisocial / delinquent behavior / conduct disorder					
Over sexualized behavior					
Somatic complaints with no known medical cause					
Attachment disorder (explain below)					
Other (explain)					

Reason for referral for treatment: In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting.

_____

_____

_____

_____

Additional Comments _____

_____

Been in counseling before?: _____

Availability: _____

2024 3rd Ave. North, Suite 312 Birmingham, AL 35203
Phone (205) 721 9893– Fax (205) 377-8057
www.strivebhm.com