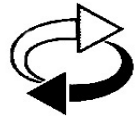




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New Perspectives
Through Compassionate Listening
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INTAKE AND REFERRAL FORM

Today's Date _____

Name of Insured Party _____ Age ____ DOB _____ Soc # _____

Client's Name _____ Relationship to Insured _____ Client's Age ____ DOB _____

Insured's Address _____ City/St/Zip _____

Phone #'s (H) () - (W) () - (C) () -

E-mail address _____

Insurance Carrier _____ ID# _____ Grp _____

Employer _____ Hire Date: _____

EAP _____ # _____

Insured's Spouse/Ex-spouse or Partner's Name _____ Age ____ DOB _____ Soc # _____

Address _____ City/St/Zip _____

Phone #'s (H) () - (W) () - (C) () -

E-mail address _____

Employer _____ Hire Date: _____

Insurance Carrier _____ ID# _____ Grp _____

EAP _____ # _____

Nature of initial contact: Scheduled Appointment Crisis Counseling Referred by: _____

Seeking Help With... or Current Stressors:

Demographics (Client's ethnicity, gender, relationship status, family factors)

Relevant Family History/ Significant Events: (Please describe and include dates for any history of mental illness, domestic violence, substance abuse, trauma, divorce, deaths, legal issues, etc.)

History of Psychological Treatment: Y N (Please describe and include dates for any prior counseling, hospitalizations, psychological evaluations, diagnosis, interventions, recovery strategies)

List Current Medications/Dosages/Medical History

List Any Drugs or Alcohol Use/Past or Present: (type, amount, frequency, date last used)

How often in the past month did you drink alcohol or use drugs?
 I do not drink or use drugs at all About once a month 2 to 3 times a month 2 to 3 times a week Once a day or more