

HEALING TRANSITIONS
CREATIVE COUNSELING FOR CHILDREN AND FAMILIES INC.
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Date: ___ / ___ / ___ ___ New ___ Reopen Referral taken by ___

Referral Source Name:	Referral Contact Telephone #:

General information:

Client: _____
First Name Middle Name Last Name

Client's date of birth: ___ / ___ / ___ **Client's ID/SS #:** _____

Address: _____
Street City State Zip Code

Phone #'s Home: _____ **Cell:** _____ **Work:** _____

Email Address: _____

Guardian/Policy holder: _____
First Name Middle Name Last Name

Guardian/Policy holder's date of birth: ___ / ___ / ___ **Policy holder's ID/SS #:** _____

Policy holder's employer: _____

Employer's address: _____

Name of MCO or other insurer: _____

Insurer telephone #: () - _____

Policy #: _____ **Group #:** _____ **Renewal date:** ___ / ___ / ___

Reason for Referral: _____

- Individual Therapy Play Therapy Family Therapy
 Couples Therapy Group Therapy EMDR Domestic Violence
 Parenting Class Therapeutic Visitation Other: _____