



Healing Transitions Creative Counseling for Children & Families Inc.

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Click on the Line at the end of the text Inside Each Text Box to Complete Form Online
Double Click on the Desired Small Auto Boxes to Shade Them Black

Date: _____

New

Reopen

Referral Taken By: _____

Individual Making Referral:

Relationship to Client: _____

Name: _____

Phone: _____

Fax: _____

(Email Address): _____

CLIENT:

(First Name): _____

(MI): _____

(Last Name): _____

(DOB): _____

(SSN): _____

(Gender): _____

(Street Address): _____

(City): _____

(State): _____

(Zip Code): _____

(Home Phone): _____

(Cell): _____

(Work): _____

(Email Address): _____

LEGAL GUARDIAN:

(Relationship to Client): _____

(First Name): _____

(Last Name): _____

(Phone): _____

Caregiver Name (If Different from Legal Guardian): (Relationship to Client): _____

(First Name): _____

(Last Name): _____

(Phone): _____

(Insurance / Copay): _____

(Member ID or Policy #): _____

(Ins Phone): _____

(Primary Insured): _____

(DOB): _____

(REASON FOR REFERRAL): _____

Individual Therapy

Play Therapy

Family Therapy

Couples Therapy

Group Therapy

EMDR

Domestic Violence

Parenting Class

Therapeutic Visitation

(Other): _____