Connecticut Therapeutic Counseling LLC
REFERRAL FORM

Client Information:

Date of Referral:	Insurance:
Date of Birth:	Insurance ID#:
Name:	Name of Insured:
Address:	DOB of Insured:
City: Zip:	
Home#:	Primary Insurance Subscriber:
Work #:	Relationship to Insurance Subscriber:
Cell#:	Email:
Secondary Insurance:	Secondary Insurance ID#:

Are you required by court of law to receive counseling as part of a legal proceeding? ☐yes ☐ no

How did you hear about CTC? _____

Emergency Contact Information:

Notify:	Phone#:
Relationship to Client:	

Treatment History:

Are you currently receiving professional counseling or psychotherapy elsewhere? ☐ yes ☐ no
Are you currently taking prescribed psychiatric medication? ☐ yes ☐ no
If yes, please list:
Prescribed by:
Reason(s) for seeking counseling:

Health and Medical:

Primary Care Physician:	Phone#:
Psychiatrist:	Phone#:
Please list any persistent symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):	
Are you having any problems with your sleep habits? ☐ yes ☐ no	
If yes, check where applicable: ☐sleeping to little ☐sleeping too much ☐poor quality sleep ☐disturbing dreams ☐other (please describe):	
Are you having difficulty with appetite or eating habits? ☐ yes ☐ no	
Do you regularly use alcohol? ☐ yes ☐ no	
Do you engage in recreational drug use? ☐daily ☐weekly ☐monthly ☐rarely ☐never	
Do you smoke cigarettes or use other tobacco products? ☐ yes ☐ no	

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Symptom Assessment:

I AM EXPERIENCING…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about certain things					
Panic Attacks: sweating, trembling, shortness of breath, heart palpitations					
Recurring distressing thoughts about trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people and places associated with trauma					
Nightmares about traumatic experience					

I AM FEELING…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I NOTICE…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
I am Angry, Irritable, Hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

Have you ever experienced any of the following?	
Extreme depressed mood	☐ yes ☐ no
Dramatic mood swings	☐ yes ☐ no
Hallucinations	☐ yes ☐ no
Homicidal thoughts	☐ yes ☐ no
Suicidal thoughts	☐ yes ☐ no
Suicidal attempts	☐ yes ☐ no If yes, when?