REQUEST FOR SERVICES

CARE COUNSELING SERVICES

Prospective Client:	**DATE OF REQUEST:**	
Soc. Sec #	**____ male ____female**	**DOB:**
Address:	**City, State, Zip Code:**	
Name of Parent(s)/Legal Guardian(s):		
Phone:	**Work Phone:**	
Alternate Emergency Contact Information Name:	**Relationship to client:**	**Phone:**
Reimbursement source:	**No insurance/Self Pay _____**	
Medicaid _____ Medicaid Number: **PASSE _____ PASSE Name/Number:**		
Private Insurance:	**Name of Policy Holder:**	**Group/ID number:**
Primary Care Physician:	**Phone:**	**Fax:**
School attending: **Phone/Fax:**	**Grade:**	
Name of Person Making Request:	**Relationship to client:**	**Phone:**

AREAS OF CONCERN (please check all that apply)

- ☐ **Academic Concerns**
- ☐ **Behavioral Concerns**
- ☐ **Social Concerns**
- ☐ **Emotional Concerns**
- ☐ **Family Concerns**
- ☐ **Other:_____**

Specific behaviors exhibited (please check all that apply)

- ☐ **Anxious or fearful**
- ☐ **Sad, depressed or irritable mood**
- ☐ **Worries excessively**
- ☐ **Hopelessness, negative view of life or future**
- ☐ **Nightmares or intrusive thoughts**
- ☐ **Low self-esteem or makes negative self-statements**
- ☐ **Lacks interest in activities**
- ☐ **Exposed to community violence, trauma**
- ☐ **Avoids reminders of trauma**
- ☐ **Low or decreased motivation**
- ☐ **Specific fears or phobias**
- ☐ **Jumpy or easily startled**
- ☐ **Clingy behavior**
- ☐ **Difficulty concentrating**
- ☐ **Trouble staying in seat or moving constantly**
- ☐ **Inattentive, distractable, forgetful**
- ☐ **Interrupts and blurts out responses**
- ☐ **Difficulty Sleeping**
- ☐ **Restless and on edge**
- ☐ **Talks excessively**
- ☐ **Aggressive**
- ☐ **Angry towards other**
- ☐ **Blames others**
- ☐ **Fights and is aggressive**
- ☐ **Argumentative and defiant**
- ☐ **Sexualized play or behaviors**

Other concerns:_____

_____

****PLEASE INCLUDE ANY OF THE FOLLOWING DOCUMENTS-**

504, IEP, EDUCATIONAL TESTING

(Rev 12/08/2023)