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):_____