INSPIRATIONAL BEHAVIORAL HEALING

Nationwide Teletherapy Behavioral Health

(771) 242-5111 – (860) 707-7242

SERVICE REQUEST FORM

Date:_____ ☐ TELEHEALTH ☐ CONSULTATION LANGUAGE:_____

Name:_____ Age:_____ DOB:_____ ☐ Male ☐ Female

Address:_____ City:_____ State:_____ Zip Code:_____

Phone #:_____ Contact and Relationship:_____ Phone #:_____

Referred by:_____ Agency:_____ Phone #:_____

If Minor, Name of School:_____ Grade:_____ IEP:_____ Yes_____No_____

Custody Status: Legal:_____ Physical Custody:_____

Preferred Therapist: Male:____ Female:____ Preferred Language:_____ Requested Therapist:_____

INSURANCE INFORMATION

Member ID Number:_____ Social Security Number:_____

Category:_____Policy Number:_____ Group Number:_____

Insurance name:_____

REASON FOR REFERRAL

_____Depression _____Anxiety ____ADD/ADHD _____Hallucinations _____Grief _____Anger Issues _____Trauma

_____Assault Behavior _____Family Problems _____Legal Issues _____Mood Swings _____Impulsive Behavior

_____Gender Identity _____History of Self Harm (When and describe):_____

____Autistic _____Behavioral Problems (Children) _____Problems in School (Describe):_____

_____

_____Domestic Violence (Is perpetrator still at home?) ___Yes ____No

_____Substance Abuse _____Drugs _____Alcohol ____Prescription Medications (How long since last use?) _____

Are you currently on medications? ____ Yes _____No

SERVICE REQUEST (CONTINUED)

Client Name:_____ DOB:_____ Date of Referral:_____

1. Is the client receiving mental health services currently? _____Yes _____No
   If yes, where:_____ Is there a current diagnosis: _____ Yes _____ No

   If yes, describe:_____
2. If a client is taking medication, list meds:_____

   _____
3. Name of Prescriber:_____

Additional Information:_____