2-STRIVE
A BEHAVIORAL HEALTH & CONSULTING AGENCY

REFERRAL/CLIENT INFORMATION SHEET

Referral Date _____ **Funding Source** _____

CLIENT INFORMATION

Name _____ **Member Id** _____

SSN ____-____-_____ **DOB** ____ /____ /_____ **Age** ____ **Sex** ☐*Female* ☐ *Male* **Race** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Mobile Phone** _____ **Work Phone** _____

Number of People in Household _____ **Languages Spoken at Home** _____

Referred By _____ **Agency** _____ **Phone** _____

Diagnosis _____ **CGAS** _____

MEDICATION HISTORY *Current and prescribed in the past 6 months*

MEDICATION	DOSAGE	FREQUENCY	ADMINISTRATION DATES
Example: Lithium 300 mg	*3 x per day*	*1/1/01- current*	

Is Client Currently Receiving Other Services? Yes ____ **No** ____

Agency _____ **With Whom** _____ **Phone** _____

TREATMENT HISTORY *Prior and current*

FACILITY	ADMIT DATE	DISCHARGE DATE	SERVICE	REASON FOR TREATMENT
Example: 2-Strive	*1/1/06*	*3/1/06*	*Therapy*	*Grief and Loss issues*

BRIEF LIST OF DETAILED PROBLEMS

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