



Adult & Child Mental Health Care, LLC

New Client Information

112 West Cervantes Street
Pensacola, Florida 32501

4622 Summerdale Boulevard
Pace, Florida 32571

Phone: 850.466.3200
Fax: 850.466.3203

Referral Source: _____ **Date of Referral:** _____

Preferred Location: ___Pensacola ___ Pace ___ Either ___In Home ___ In School/Name School _____

Counselor Preference: _____

Client's Name: _____ **SSN:** _____

Type of Insurance: _____ Insurance #: _____

Date of Birth: _____ Gender: ___Male ___Female ___Other ___Prefer not to disclose

Current Address: _____ City: _____ Zip _____

Email Address: _____ Phone: _____

Additional Client's Name: _____ **SSN:** _____

Type of Insurance: _____ Insurance #: _____

Date of Birth: _____ Gender: ___Male ___Female ___Other ___Prefer not to disclose

Current Address: _____ City: _____ Zip _____

Email Address: _____ Phone: _____

Additional Client's Name: _____ **SSN:** _____

Type of Insurance: _____ Insurance #: _____

Date of Birth: _____ Gender: ___Male ___Female ___Other ___Prefer not to disclose

Current Address: _____ City: _____ Zip _____

Email Address: _____ Phone: _____

Other Contact Information:

If client is a **minor**, please indicate parent/guardian's information. If client is an **adult**, please indicate emergency contact.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Please describe the reason for referral: What are the presenting problems/symptoms?

- Stress/Anxiety
 Depression
 Anger issues
 Trauma
 Divorce/Relationship Problems
 ADHD
 Communication Difficulties
 School/Job Related Stressors
 Behavioral Problems
 Autism
 Other:

For Office Use Only: Initials of ACMHC personnel processing referral: _____ Date: _____

Pensacola Distance: _____ Pace Distance: _____ Entered in Dropbox Completed

Referral via: Phone Fax In Person