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:_____

Do you have a preference on the location where services will be received? (We will attempt to honor if possible)

In our offices: ___Pensacola ___ Pace ___ Either ___In Home ___In School--Name of School_____

Client Information:

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:

_____

_____

_____

Please indicate if you have a preference in the Counselor assigned:_____

For Office Use Only: ACMHC personnel processing this referral:_____ Date:_____