DHA DAVID HOY & ASSOCIATES
Therapeutic Counseling | Change Your Mind

Date: _____
Referring Person's Name & Relationship to client: _____
Referring Agency/Source: _____
Phone: _____ Fax: _____

Client Name: _____ **DOB**: _____

Gender: _____ Culture/Ethnicity: _____ Primary Language/ESL: _____

All Parents/Guardians involved & Relationship to client (for minor clients):

_____

Address: _____ **Phone:** _____

_____ **Phone:** _____

Is it okay to leave a voice mail at these phone numbers if you are not able to answer? **Y/N**

Insurance Provider: _____ **MA/PMAP/Private (circle one)**
For Private Insurance clients: Would you like us to call you back with a benefit explanation after we verify coverage? **Y/N**

ID# _____ **Group #** _____

Services Requested (circle all that apply): Outpatient Therapy – In-home Therapy – In-home Family Therapy – Individual Skills – Family Skills

Location: Golden Valley _____ Chaska _____ Hutchinson _____ New Brighton _____
(In-home Only)

Client Availability: M: _____ T: _____ W: _____ Th: _____ F: _____

Current Mental Health Diagnosis: _____

Other Mental Health Providers: _____
Name Phone

Family & Household Information (Include Pets): _____

_____

Reason for Referral/Specific Concerns: _____

_____

_____

_____

Staff Requested: _____

***Please fax the following information to 763-544-1008, Attn: Sara Hensche**

- This form, completed
- Release of information
- **Most Recent Diagnostic Assessment – if there is not a current Diagnostic Assessment check this box** ☐