Today's Date: _____

NEW DAWN COUNSELING & CONSULTING, INC.

2200 Outlet Center Drive Suite 430 Oxnard, CA 93036
Phone (805) 278-0799 Fax (805) 278-0781 www.newdawncnc.com

Name of Client:_____ Ethnicity:_____ Date of Birth: _____

Address: _____ City: _____ Zip: _____ Daytime Phone: _____

Do we have permission to leave a voicemail message on Client or Parent/Guardian's phone? Yes No

If client is a minor, the name of Parents/Guardians: _____ _____

School: _____ Grade Level:_____ Teacher: _____

Number of people living in the home: _____ Preferred language spoken in home: _____

Does client need a Spanish speaking, bilingual counselor: Yes No Does client have Medi-Cal: Yes No

Medical #: _____ Issue Date: _____ (Please attach copy of Medical card.)

If client has received mental health services in the past, when _____ and where _____

If this is a referral for **Triple P services**, has the client received **Triple P, Level 3** services: YES NO

REASON FOR REFERRAL:_____

_____

PLEASE CHECK ANY HIGH RISK CHARACTERISTICS:

____ Nightmares
____ Defiance/breaking rules
____ Inability to get along
____ Frequent temper tantrums
____ Physical fighting/hitting/bitir
____ Verbally abusive
____ Sadness/lack of energy
____ Drug/alcohol use
____ Eating disorders
____ Fearful/anxious
____ Recent loss/trauma
____ Crying Spells

____ Disheveled appearance
____ Stealing/Lying
____ Physical/sexual abuse or neglect
____ Poor hygiene
____ Decline in classroom performance
____ Disruptive in class
____ Falls asleep/lethargic in class
____ Lack of concentration/inattentive
____ Unable to sit still
____ Difficulty following instructions

____ Clinging/shadowing others
____ Excessive need for reassurance
____ Isolated/withdrawn
____ Overly concerned with pleasing others
____ Puts self down frequently
____ Scapegoat/picked on
____ Irritable
____ Suicidal/Homicidal thoughts
____ Distancing parents
____ Parental drug/alcohol abuse
____ History of parental abuse

Name and title of Referring Party _____ with_____
(Please print) (Name of Agency, Organization, School, etc)

Referring Party's phone number:_____ Fax Number_____

Release of Information:

I hereby authorize the release of above information to and from New Dawn Counseling & Consulting, Inc. for the purpose of referral and service coordination with _____.
(Name of referring party, school, agency, organization, etc.)

Por la presente autorizo la liberación de información a/ y de New Dawn Counseling & Consulting, Inc. *para la recomendación y la coordinación de servicios con* _____.
(Nombre de la persona, escuela, agencia, organización, etc.)

_____ _____
Signature Parent/Guardian/ *Firma del Padre, Madre o Tutor* Date/ *Fecha*

For New Dawn Counseling & Consulting, Inc. Use Only:
Program assigned: EPSDT (Child/Youth Medi-Cal) Triple P Triple P NfL KP

Revised 7/2016