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- ____ Isolated/withdrawn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