

# Personal Growth Counseling LLC.



233 S. 13<sup>th</sup> St., Suite 800E, Lincoln, NE 68508  
Phone: (402) 435-4700 Fax: (402) 435-4701

Date of Referral: \_\_\_\_\_

Referring Agency: \_\_\_\_\_

Referral Phone: \_\_\_\_\_

Referral Fax: \_\_\_\_\_

Client's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Client's Address: \_\_\_\_\_

Current Placement:  Home  Foster Home  Group Home  Other (specify) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Other number to be reached at: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

**Reason for Referral/ Presenting Problem:**

**Treatment/Medication History:**

*I have had the opportunity to review the office policy and contract, including confidentiality and authorize Personal Growth Counseling LLC to provide therapeutic services for the above named client.*

\_\_\_\_\_  
**Signature of client or legal guardian**