THRIVE Trauma Recovery Child Referral Form

Client Name ____DOB________Age________

Caregiver Name ________________________________Caregiver Title_____________________
(parent, foster parent, caseworker)

Address:____

Email____Phone_________________________

Name/Title of Person filling out form____

Today's Date: __________________ Custodial status____

Client's School Grade________IEP? Y/N____Cognitive/behavioral barriers______________________

Recent MH Diagnosis______________Type of Insurance____________________________________

Please indicate how many times the client has experienced any of the following:

In Utero/Birth Trauma	
Childhood Neglect	
Medical Trauma	
Sexual Abuse	
Rape	

Emotional Abuse	
Death of a Caregiver	
Natural Disaster	
Bullying	
Motor Vehicle Accident	

Placement Moves	
Witnessing Traumatic Event	
Childhood Physical Abuse	
Removal from Birth Parents	
Adoption	

Please list known significant experiences, circling those most significant in each age category:

0-5____

____

5-10____

____

10-15____

____

15-19____

____

If child is in custody, CSI or equivalent thorough child welfare history crucial to treatment process.

Is client currently abusing drugs/alcohol? Y / N ________ Suicidal?________________________

What are your goals for treatment?

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________________________ ____