DHA DAVID HOY & ASSOCIATES
Therapeutic Counseling | Change Your Mind

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

Client Name: _____ **DOB:** _____

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

Parent/Guardian: _____Email:_____

Address: _____ **Phone:** _____
_____ **Phone**:_____

Is it okay to leave a voice mail at these phone numbers if you are not able to answer? **Y/N**
Is it okay to send text appointment reminders to this number? **Y/N**

Insurance Provider:_____ **MA/PMAP/Private (circle one)**
ID#_____ **Group #**_____

Do you have secondary insurance? **Y/N** _____

Services Requested (circle all that apply): Outpatient Therapy – In-home Therapy – In-home Family Therapy – Individual Skills – Family Skills
In-home/Skills services are only covered by MA or PMAP Plans

Location: Golden Valley _____ Chaska _____ Telehealth _____

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

Current Mental Health Diagnosis:_____

Other Mental Health Providers: _____
Name Phone

Are Mental Health Services Court Ordered? If yes, what was the offense? Y/N
Offense: _____

Family & Household Information (Include Pets): _____
_____

Reason for Referral/Specific Concerns: _____
_____
_____

Staff Requested: _____

***Please fax the following information to 763-544-1008, Attn: Admin Staff**

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