Outpatient Counseling Request Form

Client Name: _____ DOB: _____
Gender: _____

If applicable:
Guardian's Name: _____ Relationship:_____ Phone:_____
Guardian's Name: _____ Relationship:_____ Phone:_____

Address: _____ City: _____ State: _____
Phone: _____ Email: _____
School/Employer: _____ Grade: _____

Type of Services: Individual_____ Family_____

Substance use assessment (ASI) Adult_____ Adolescent_____

Preferred appointment time: _____

Safety Concerns: _____

Insurance Yes☐ No☐

*Once you have completed this form, please download and email it to our counseling services team at: counselingservices@casperycc.org