Fax to:
Family Forces
Fax: 858-277-7908 Ph: 858-277-7907

Name of School	
Phone	

(Full Legal Name)

Student	First	Middle	Last	Age	Sex	Date of Birth

Social Security Number:	Grade:	Teacher/Counselor:	Ethnic Origin
Address			White
			Black
			Hispanic
City		Zip	Asian
			Native American
			Other______________

PARENT/GUARDIAN:	Relationship

Telephone Home	Work	Other/Cellular Phone

Has the family given consent for Family Forces to contact Yes ______ No ______

Signature of family member/guardian: ______________________

Name of school personnel that spoke with the family about counseling: ______________________

Date of Consent: __________ Who did you contact? ______________________

Best time and place to reach the family: ______________________

Funding: Please check if known

Tricare: Yes __________ No __________

Sponsor SSN: ______________________

Sponsor Name: ______________________

Other Health Insurance? Yes __________ No __________

Current or Previous (If known)

Counseling: Yes ☐ No ☐

Where: __________ When: __________

With whom: ______________________

Medication Yes ☐ No ☐ Date: __________

If yes, who prescribed? ______________________

Type of medication:

Reasons for Request for Mental Health Evaluation:

Please check all that apply to this student

☐	Disruptive Behavior	☐	Anxious	☐	Death of Family Member
☐	Inappropriate Behavior	☐	Social Problems	☐	Divorce
☐	Anger outburst	☐	Moody	☐	Financial Problems
☐	Talks back	☐	Alcohol/Substance Abuse	☐	Other __________
☐	Fights	☐	Family Issues	Academic concerns: ☐	Performance
☐	Sad	☐	Health Problems	☐	Attendance
☐	Withdrawn/Isolates	☐	Separation		

Additional Comments/Concerns:

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Your name:	Position:	Your phone:	Today's Date

Revised 01/18