Children's Center for Hope & Healing, Inc.

Referral Information for Adult Services

(CCHH USE ONLY) **CLIENT # _____**

Date: _____ **Interviewer:** _____

Referred By: _____ **Phone #** _____

County of Referral: _____

Client Name: _____ **Gender:** _____

Age:_____ **Date of Birth:**_____ **Ethnic Origin:** _____

Address: _____ **County:** _____

_____

_____

Phone: (Cell) _____ ****PLEASE INDICATE NUMBER**

(Home) _____ **WHERE MESSAGE CAN BE LEFT****

Marital status: _____

Names & ages of other individuals living in home: _____

_____

Childhood Sexual Abuse History Information:

Offender: _____ Age of offender when abuse occurred:_____
Sex of offender: _____ Ethnic origin of offender: _____
Relationship (if any) to client: _____
Client age when abuse occurred: _____
Was the abuse disclosed to an adult? _____To whom? _____
Was it reported to authorities? _____Were charges brought? _____
State and county where offense took place? _____
Systems Involved (indicate county and contact person if known): _____
_____

Offender:_____ Age of offender when abuse occurred:_____
Sex of offender:_____ Ethnic origin of offender:_____
Relationship (if any) to client:_____
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Was the abuse disclosed to an adult? _____ To whom? _____
Was it reported to authorities? _____ Were charges brought? _____
State and county where offense took place? _____
Systems Involved (indicate county and contact person if known): _____
_____

Have you ever received therapy for sexual abuse issues? _____

If so, with whom, where, and how long? _____

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What prompted you to inquire about our services at this time?

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