Loving Hearts of LA
Mental Health & PCA Services
Healing guided by the mind, through the heart

Date: _____ Loving Hearts Location: Lafayette

Referring Source

Agency/School: _____ Person of Contact: _____

Phone: _____Fax: _____ Email: _____

Client Name: _____ Date of Birth: _____

Guardian/Representative: _____ Phone: _____

Address: _____

Medicaid Information: _____

Race: _____ Ethnicity: _____ € Female € Male

Services Requested (Please check all that apply):

- € Initial Assessment
- € Medication Management
- € Psychotherapy Services
- € Personal Care Assistance

PLEASE PHONE, FAX, OR DELIVER REFERRAL AND INFORMATION TO LOCAL LOVING HEARTS OF LA OFFICE:

2448 Johnston St. Suite B
Lafayette, LA 70503
Office: 337.233.7250
Fax: 337.233.7104

Email: referralsnola@lovingheartsofla.com

To be completed by Loving Hearts staff.

LH Intake Contact: _____ Date of Initial Contact with Client: _____

Initial Assessment Appointment: € Yes € No If Yes, Date: _____ Time: _____

Comments: _____

_____

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Symptom Checklist: Please check all symptoms that are applicable

Complains of aches/pains		School grades dropping	
Spends more time alone		Is down on himself/herself	
Tires easily, has little energy		Visits doctor with doctor finding nothing wrong	
Fidgety, unable to sit still		Has trouble sleeping	
Has trouble with teacher(s)		Worries a lot	
Less interested in school		Takes unnecessary risks	
Acts as if driven by a motor		Gets hurt frequently	
Daydreams too much		Seems to be having less fun	
Distracted easily		Acts younger than children his or her age	
Is afraid of new situations		Does not listen to rules	
Feels sad, unhappy		Does not show feelings	
Has trouble concentrating		Teases others	
Less interest in friends		Blames others	
Fights with others		Steals	
Is irritable, angry		Lies	
Feels hopeless		Hurts animals	
Absent from school		Starts/plays with fire	

Previous Diagnosis: _____

Current medication: _____

Past Mental Health services: Yes/No? Where? _____

Other notes: