Turning Point Counseling Services

WHERE GROWTH BEGINS

Application for Services

Client Name:	Partner/Parent(s) Name(s):

Client phone Home #: ☐ Preferred contact number ☐ OK to leave message	Work #: ☐ Preferred contact number ☐ OK to leave message	Mobile #: ☐ Preferred contact number ☐ OK to leave message & text
Partner/Parent phone Home #: ☐ Preferred contact number ☐ OK to leave message	Work #: ☐ Preferred contact number ☐ OK to leave message	Mobile #: ☐ Preferred contact number ☐ OK to leave message & text

Client Email:	Partner/Parent(s) Email:

Street address:

City:	State:	ZIP code:

Date of birth:	Partner's date of birth:
Client's relationship status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Length of relationship:

Emergency contact info:
Referred by:

Person responsible for payment:	Address of person responsible for payment: Street address: City: State: Zip:

Employment status: ☐ Employed ☐ Student ☐ Part-time ☐ Full-time ☐ Other
Employer or School attending:
Religious affiliation:
What previous counseling have you had?
What precipitated counseling?
Goals & expectations for counseling:
Family Composition: (names and ages of family members, roommates, and/or others living in the home)

Family History of substance abuse, mental health, or behavioral issues:
Current medications:
Current or past substance use or abuse:
Medical history and current symptoms:
Legal history: (litigation, detainment, DUI, arrest or other involvement)

Safety

☐ There is a firearm or other weaponry in the home. If so, please elaborate:

☐ I have previously harmed or thought about harming myself. If so, please elaborate:

☐ I currently harm or think about harming myself. If so, please elaborate:

☐ I currently harm or think about harming other people, animals, or objects. If so, please elaborate:

What else would you like me to know?

Authorization for therapy

Please sign after reading Informed Consent and Description of Services.

I/We (print names) ____ authorize Turning Point Counseling Services LLC to provide therapy to me, us, and/or my child(ren).

Signature of Client:	Date:
Signature of Client, Partner, Parent, or Guardian:	Date:

Turning Point Counseling Services LLC Agreement to Provide Therapy:

Signature of Therapist:	Date:

Thank You.