Turning Point

Center for Psychological and Family Growth, LLC

NEW CLIENT INTAKE Today's Date ______________________

Client's Name ____
First Middle Initial Last

Address ___________________________ City ________________________ State ______ Zip _______

Age _______ DOB: _____________ Marital Status: Single Married Divorced Separated Widowed

Client's e-mail ____

Social Security # ______________________ Home Phone # ____________________________

Occupation ____________________________ Work Phone # ____________________________

Employer _____________________________ Cell Phone # ______________________________

Spouse/Significant Other Name ________________________SS# ______________________________

Spouse/Significant Other Employer ____________________ PH# ______________________________

INSURANCE INFORMATION

Company Name and Address	Name of Policy Holder	Policy #
________________________________	______________________	_______________________
________________________________	Name of Group	Group #
________________________________	______________________	_______________________
2nd Company Name/Address	Name of Policy Holder	Policy #
________________________________	______________________	_______________________
________________________________	Name of Group	Group #
________________________________	______________________	_______________________

Referral Source: ___ Doctor (Name?) ___________ Ins Co. ___ Friend ___ Yellow Pages ___Other?)____

When confirming appointments, whom should we call? _____________________________________

At What phone number? ____

If you do not wish to receive an appointment confirmation call, please let the office staff know at each appointment. If we call, and you are not available, may we leave a message: YES___NO_____

In the case of an emergency, whom should we contact? ______________________________________

Phone Number ____

FAMILY INFORMATION:

IF CLIENT IS A MINOR (Please complete the following):
Name of Parent or Legal Guardian: (Please Circle One)**:**________________________________

Adults and children living in child's primary residence

Name	Age	Relationship	SSN(parents)	Work/cell phone#
________________	____	____________	____________	_________________
________________	____	____________	____________	_________________
________________	____	____________	____________	_________________
________________	____	____________	____________	_________________
________________	____	____________	____________	_________________

Adults and children living in child's secondary residence, if applicable

Name	Age	Relationship	SSN	Work/cell phone#
________________	____	____________	____________	_________________
________________	____	____________	____________	_________________
________________	____	____________	____________	________________
________________	____	____________	____________	_________________
________________	____	____________	____________	_________________

IF CLIENT IS AN ADULT (Please complete the following):

Father:	___________________________	Age:_________	Occupation: __________
Mother:	___________________________	Age:_________	Occupation: __________
Stepmother:	________________________	Age:_________	Occupation: __________
Stepfather:	_________________________	Age:_________	Occupation: __________
Siblings:	___________________________	Age:_________	M/F (circle one)
	___________________________	Age:_________	M/F
	___________________________	Age:_________	M/F
	___________________________	Age:_________	M/F
	___________________________	Age:_________	M/F
Children:	___________________________	Age:_________	M/F
	___________________________	Age:_________	M/F
	___________________________	Age:_________	M/F
	___________________________	Age:_________	M/F
	___________________________	Age:_________	M/F

Describe the client's home environment during childhood_____________________________________

____

Is there a history of any of the following in your current family or your family of origin? Please Explain:

Alcoholism/Drug Abuse Y/N ____
Mental Illness Y/N ____
Physical/Sexual Abuse Y/N ____
Domestic Violence Y/N ____
Emotional Abuse Y/N ____
Legal Problems Y/N ____
Severe Physical Illness Y/N ____

EDUCATION

Degree or highest grade completed____
School____
Average Grades____
Currently in school? Where? Goal? ____

MEDICAL HISTORY

Primary physician ____
Other current physicians' ____

Current medications and prescribing M.D. ____
____
____

Current medical conditions/problems/symptoms ____
____
____

History of surgery ____
____
____

Pharmacy you use, phone #/location ____

Disability? Y/N Type ____

History of inpatient or outpatient psychiatric care/counseling? Y/N ____________________
When, where, nature of problem, outcome: ____

Any history of suicide attempts: Y/N When? ____

Any history of violence? Y/N Arrests? Y/N Please explain ____________________
____

Any History of Birth Defects or Developmental Delays? Y/N ____________________

Current legal conflicts: Y/N Please explain ____

____

Please rate each of the following **current symptoms** on the following scale:

0 (Absent), 1 (Mild), 2 (Moderate), 3(Severe):

____Moodiness	____Low self esteem	____Suspiciousness
____Worrying	____Depressed mood	____Delusions
____Panic Attacks	____Loss of pleasure	____Hallucinations
____Phobic Fears	____Poor or excess sleep	____Paranoid thinking
____Trauma Memories	____Poor or excess appetite	____Grandiosity
____Flashbacks	____Low energy	____Strange thinking
____Obsessions	____Poor concentration	____Strange behavior
____Compulsive Rituals	____Memory problems	____Confusion
____Nightmares	____Suicidal thoughts	____Disorganized thinking
____Emotional Numbing	____Racing thoughts	____Sexual Trouble
____Perfectionism	____Rapid speech	____Relationship Problems
____Social Isolation	____Elated mood	____Work Problems
____Excess Dependency	____Poor impulse control	____Academic Problems
____Self centered	____Anger	____Legal Problems
____Overly Controlling	____Blaming	____Alcohol Abuse
____Overly guilty	____Homicidal thoughts	____Abuse of Street Drugs
____Binge Eating	____Headaches	____Abuse of Prescribed Drugs
____Purging/Vomiting	____Other bodily pain	____Nicotine Use (amount?) _____
____Laxative use	____Bodily preoccupation	____Caffeine Use (amount?)_____
____Excess dieting	____Epilepsy	____Other ____________________

Reasons for seeking help ____
____

Therapy goals ____
____

Personal Strengths ____
Personality Type ____

Any other information your therapist should know ____
____
____

I, THE UNDERSIGNED PARTY, DO HEREBY GIVE MY CONSENT TO ____________________, OF TURNING POINT CENTER FOR PSYCHOLOGICAL AND FAMILY GROWTH, LLC FOR ASSESSMENT AND/OR PSYCHOTHERAPEUTIC TREATMENT OF ________________________.

Client's Name

Client Signature ________________________________ Date Signed ___________________________

Parent/Guardian Signature ________________________ Date Signed ___________________________

Witness ____ Date Signed ___________________________