Turning Point Counseling Center

Date of Intake: _____

New Client Profile

GENERAL INFORMATION:

Client Name: _____
First Middle Last

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address if different from physical address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ ☐ Male ☐ Female ☐ Other/Identify as: _____

Race (Optional): ☐ White ☐ African-American ☐ Latino ☐ Other: _____

Contact Information:

Cell Phone: _____ May we contact your cell: ☐ Yes ☐ No

Would you like appointment reminders sent via text to your cell phone: ☐ Yes ☐ No

Home Phone: _____ May we contact your home phone: ☐ Yes ☐ No

Email: _____ May we email you: ☐ Yes ☐ No
(Please note email correspondence is not considered to be a confidential medium of communication)

Employer Name: _____ Phone: _____

School: (if a student) _____ Grade: _____

Marital Status:

Married: __ Partner ___ Separated: ___ Divorced: ___ (# of times ___) Widowed: ___ Single: ___

Spouse/Partner Information:

Spouse/Partner Name: _____ Date of Birth: _____

Cell Phone: _____ Home Phone: _____

Employer Name: _____ Phone: _____

In the event of an emergency may we contact your spouse/partner? ☐ Yes ☐ No

Emergency Contact if other than spouse/partner:

Name: _____ Phone Number: _____ Relationship: _____

Members of Immediate Household:

Name	Relationship	Age

Were you referred to us? ☐ Yes ☐ No

Referral Source (ex: internet, church, friend): _____

Do you have a church affiliation or spiritual influence? ☐ Yes _____ ☐ No

Custodial Information (if client is a minor):

Please list below names of those with legal parental rights to this minor:

Are parents of child divorced? ☐Yes ☐No If yes, is custody shared? ☐Yes ☐No

Have all custody arrangements been resolved/finalized? ☐Yes ☐No

Note: copy Legal Guardianship paperwork or copy of final divorce decree may be requested

Biological Father: _____ Legal Guardian: ☐Yes ☐No

Address if different from above: _____

Phone if different from above: _____

Biological Mother: _____ Legal Guardian: ☐Yes ☐No

Address if different from above: _____

Phone if different from above: _____

Other Legal Guardian: _____ Phone: _____

Address if different from above: _____

Phone if different from above: _____ Relation to client: _____

Other Legal Guardian: _____Phone: _____

Address if different from above: _____

Phone if different from above: _____ Relation to client: _____

Commercial Insurance

If you are using insurance and are not the primary policyholder please leave the primary cardholder information below to ensure your benefits can be obtained. (If self, please skip this section)

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Please note we will obtain a copy of your insurance card for our records to determine eligibility and benefits.

Do you have a secondary Insurance? ☐Yes ☐No
If yes, please list primary cardholder information below

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Client History Profile

Client Name: _____

Presenting Problem: Please give a brief description of why you are decided to see our counselor today?

_____

_____

_____

_____

History of prior mental health treatment:

Have you received mental health treatment or therapy in the past? ☐Yes ☐No

If yes, what was the reason for seeking therapy at that time? _____

Therapist/Agency Name	Address	Phone

Family History:

Is there a family history of mental health/behavioral related disorders? ☐Yes ☐No

If yes, please specify below

	Mood	Anxiety	Psychosis	Behavioral	Anger	Suicidal Ideations/Attempts	Substance Abuse
Mother							
Father							
Siblings							
Extended							

Addictions History:

Are you currently, or have you ever abused any of the substances listed below? ☐Yes ☐No

Does client have family history of addictions or substance abuse? ☐Yes ☐No

Are there other forms of addiction present (internet, pornography, gambling, sexual)? ☐Yes ☐No

Please List: _____

Substance Use History:

Substance	Currently Using/Never Used (specify)	Date of first Use	Frequency of use	Dose (Amount)	Date of last use	Family History
Alcohol						
Nicotine						
Opiates						
Amphetamines						
Barbiturates						
Hallucinogens						
Marijuana						
K2						
B2						
Bath Salts						
Inhalants						
Other						

Abuse History:

Do you have a history of physical, sexual, or emotional abuse? ☐Yes ☐No

Do you have a history or domestic violence? ☐Yes ☐No

Do you have a history of neglect? ☐Yes ☐No

Criminal History:

Have you ever been incarcerated? ☐Yes ☐No (If yes, specify below)

Jail/Prison (Location)	Conviction	Duration of Incarceration (Dates)	Probation (Duration)

Medical/Health Screen:

Who is your primary care physician?

Name: _____ Address: _____ Phone: _____

Are you currently receiving medical treatment for any conditions? ☐Yes ☐No

If yes, please specify: _____

Are you currently taking any prescription medications ☐Yes ☐No (If yes, please specify)

Medication	**Dose**	**Frequency**	**Prescribing Physician**

Are you currently sexually active? ☐Yes ☐No

Have you ever or are you currently experiencing any chronic health concerns (Major injury, surgery, hospitalization, major illness)? ☐Yes ☐No (If yes please explain.)

_____

_____

On a scale of 1 to 10 what is your level of distress today: (1 very little / 10 – very distressed) _____

Are you currently experiencing any suicidal thoughts? ☐Yes ☐No

Have you experienced any suicidal ideations in the past? ☐Yes ☐No

If yes, did you have a plan? ☐Yes ☐No

Please check any of the following below that apply to you today:

☐ Stress ☐Anxiety ☐Depression ☐Substance Abuse ☐Physical Pain

☐Financial Worries ☐Physical Abuse ☐Emotional Abuse ☐Grief

☐Marriage/Partner ☐Anger ☐Hopelessness ☐Trauma ☐Family

☐ Other: Please explain: _____

HIPAA / Informed Consent for Treatment

Please read below and initial (client or guardian of minor)

_____ I understand that I am consenting only to mental health treatment that my counselor is qualified to provide within the scope of the professional (or his/her supervisor's) license, certification, and training he/she has obtained. I understand that if I am seeing an unlicensed master's level therapist who is obtaining clinical hours for licensure that my case may be discussed with their licensed clinical supervisor to ensure you the best treatment possible.

_____ I understand my treatment will be kept confidential and is protected by Federal Law and regulations (see 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal Laws and 42 CRF part 2 for Federal regulations).

_____ Release of information will only occur by my signed and witnessed consent. In compliance with the Laws of the State of Indiana, the exceptions to this rule would include: suspected child abuse/neglect, disabled or elder abuse/neglect, danger to self or others, a court order, and in the treatment of minors to biological parents or legal guardians (except those minors seeking treatment for substance abuse.)

_____ I agree that I am fully responsible for payment at the time of service unless prior arrangements have been made. I agree to adhere to the fees, scheduling and cancellation policies of Turning Point Inc. I understand that in the event that I **no call/no show for my appointment at least 24 hours in advance** that I will be charged a $4**0 fee**.

_____ I understand that Turning Point Counseling will be using a HIPAA compliant program for any video sessions. Confidentiality will be as secure as the HIPAA program and Turning Point Counseling can enforce. I agree to accept possible risk.

_____ I understand that in the event that I miss two consecutive sessions without prior communication with Turning Point Counseling Center services will be suspended for 30 days.

_____ I understand my clinical information/treatment plan/diagnosis may be shared with my insurance company should said company request further information needed for payment of services.

_____ If you have authorized such, a confidential voicemail/text message may be left 24 hours a day, 7 days a week. Our therapist's will try to return all messages within 24-48 hours. If there is an emergency, please call 911 or go to the closest emergency room.

_____ If the client is a minor, I certify I have the legal right to authorize treatment for the minor.

_____ I affirm that I have been given a list of emergency resources in our area should I or one of my dependents ever need emergency care or intervention. (located in your blue folder)

_____ Electronic Communication – cell phones, email, etc may be used within the scope of treatment by mutual choice between you and your therapist. While Turning Point takes every precaution for security and privacy, if you choose to use electronic devices you waive your right to confidentiality within them

_____ I affirm that Turning Point Inc. has given me a copy of the HIPAA privacy practices and that I am aware of my HIPAA rights. (located in your blue folder)

Acknowledgement and Consent

My signature below indicates that I have read, understood, and consented to the above items and the provisions set forth by HIPAA regulations:

Client(s) Signature:

_____ **Date:** _____

_____ **Date:** _____

Custodial Parent/Guardian (if client is a minor):

_____ **Date:** _____

Counselor Signature: _____ **Date:** _____