A Turning Point

CLIENT INFORMATION - YOUNG ADULT/ADOLESCENT

Client Full Name	Age	☐ M ☐ F	Date of Birth	**Today's Date**

Home Address: Street Apt # City Zip	Home Phone ( )

Employer	Social Security Number	Cell Phone ( )

Who is financially responsible for payment? How will the bill be paid today?	Email	Work Phone ( )

Father/Guardian's Information

Name	Age	Date of Birth	Home Phone ( )

Home Address: Street Apt # City Zip	Cell Phone ( )

Employer	Social Security Number	Email	Work Phone ( )

Mother/Guardian's Information

Name	Age	Date of Birth	Home Phone ( )

Home Address: Street Apt # City Zip	Cell Phone ( )

Employer	Social Security Number	Email	Work Phone ( )

Other Family Members

Name	Age	Relationship	Name	Age	Relationship
Name	Age	Relationship	Name	Age	Relationship

Medical Information

Previous Therapy? ☐ Yes ☐ No	When:	For How Long:	Purpose	Evaluation of Success

Important Medical History	Current Prescriptions:

Referral

Whom May We Thank For Referring You To Us? (please circle or write in)

Website: _____

Person: _____

Other: _____