TURNING POINT PROFESSIONAL COUNSELING
10505 N. 69th St. #200
Scottsdale, AZ 85253

Phone: (480)-707-7406 **www.scottsdale-therapist.com**

CLIENT INTAKE FORM

(Please Print)

Today's Date _____/_____/_____ **Therapist**_____

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code		Home Phone No. ( )
P.O. Box	City	State	ZIP Code		Cell Phone No. ( )
Occupation	Employer				Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Dr. _____ ❑ Friend ❑ Website

❑ Family ❑ Close to Home/Work ❑ Psychology Today ❑ Other _____

Email Address:	Alternative Email Address:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.