



APPLICATION FOR ADMISSION

Resident Information

Date of Application: _____

First Name: _____ Last Name: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Cell Phone Number: _____ Email address: _____

Father's Information

Name: _____ Living Deceased

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Stepmother / Significant Other's Full Name (if applicable): _____

Mother's Information

Name: _____ Living Deceased

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Stepfather / Significant Other's Full Name (if applicable): _____

Financial Responsibility Information

Guarantor's Name: _____ Relationship: _____

Guarantor's Mailing Address (if different from above) _____

Work Phone: _____ Fax: _____ Cell Phone: _____

Sibling/Children Information

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Emergency Contact Information

Name: _____ Phone: _____

Relationship to Applicant: _____

Referral Source Information

How did you or your family first come to know about Turning Point?

Counselor at current treatment program. Program Name: _____

Counselor: _____ Email: _____

Therapist Name: _____ Email: _____

Internet Search

Friend

Turning Point Alumni

Emotional/Mental Health Diagnoses

Has the applicant been given a diagnosis by a mental health professional?

Diagnosis	Date Given	Name of Professional

Current Medications

Name of medication	Name of Prescribing Physician	Date Prescribed	Dosage/Schedule	Reason for medication

Significant Medical History

Date of Last Use: _____

General health condition: Excellent: Good Average Poor

Does the applicant have any food restrictions? Yes No If yes, please explain: _____

Allergies _____

List/Explain any chronic conditions (asthma, heart murmur, diabetes, enuresis, etc.)

History of surgeries/broken bones _____

Has applicant ever been hospitalized other than for above described surgeries or fractures? If so, why and for how long?

Please check any of the following that apply to the resident:

Event/Behavior	Yes	No	Event/Behavior	Yes	No
Depression			Running away		
Suicide			Death of parent or guardian		
Hearing Voices			Death of close friend		
Arson / Fire setting			Has been arrested		
Cruelty to animals			On probation		
Psychiatric Hospitalization			Violence towards others		

For any of the items that are marked "Yes", please provide explanation:

Addiction Treatment/Hospitalization

Current Treatment Programs/Hospitalization:

1) Program/Facility Name: _____ Dates of Treatment: _____

Previous Treatment Programs/Hospitalization:

1) Program/Facility Name: _____ Dates of Treatment: _____

2) Program/Facility Name: _____ Dates of Treatment: _____

Mental Health Professionals (psychiatrist, psychologist, educational consultant, therapist, etc.)

1) Name: _____ Dates of Treatment: _____

Title: _____

Phone: _____ Fax: _____

2) Name: _____ Dates of Treatment: _____

Title: _____

Phone: _____ Fax: _____

3) Name: _____ Dates of Treatment: _____

Title: _____

Phone: _____ Fax: _____

Recent Employment History

Employer: _____ To/From: _____

Title/Job Responsibilities: _____

Employer: _____ To/From: _____

Title/Job Responsibilities: _____

Hobbies/Activities of Interest

Addiction History (Please check and comment)

	Substance	Type	Frequency	Age of first use	Date of last use
	Alcohol				
	Marijuana				
	Cocaine				
	Opiates				
	Benzodiazepine				
	Barbiturates				
	Phencyclidine (PCP)				
	Methadone				
	Suboxone				
	Methamphetamines				
	Inhalants				
	Nitrous				
	Ecstasy				
	Ketamine				
	Tramadol				
	Hallucinogens				
	Other (list)				



PRIMARY TREATMENT REFERENT INFORMATION

Resident

First Name: _____ Last Name: _____ Date of Admission: ____/____/____

Primary Treatment Program

Name: _____

Address: _____

City/State/Zip: _____

Contacts

Primary Care Counselor: _____

Phone Number: _____ Ext: _____

E-Mail Address: _____

Aftercare Coordinator: _____

Phone Number: _____ Ext: _____

E-Mail Address: _____

Interventionist/Other: _____

Phone Number: _____ Ext: _____

E-Mail Address: _____

Requested Updates (For Staff Use Only)

Frequency: _____

Method (Phone/E-Mail): _____

Client Contact: _____



TURNING POINT
ACADEMIC RECORD REVIEW

Client Information

Date of Application: _____

First Name: _____ Last Name: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____

Cell Phone Number: _____ Email address: _____

Skype Name (if applicable): _____

Preferred Means of Contact: Home Phone Cell Phone E-mail

Educational History

Name of High School Attended: _____ Current High School Grade Level: _____

Name(s) of College(s) Attended (if any): _____

_____ Current College Grade Level: _____

Have you taken the SATs? Yes No Have you taken the ACTs? Yes No

Client's Parent/Guardian #1:

First Name: _____ Last Name: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Cell Phone Number: _____ Email address: _____

Marital Status: Married Divorced Single Other: _____

Preferred Means of Contact: Home Phone Cell Phone E-mail

Client's Parent/Guardian #2:

Not applicable

First Name: _____ Last Name: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Cell Phone Number: _____ Email address: _____

Marital Status: Married Divorced Single Other: _____

Preferred Means of Contact: Home Phone Cell Phone E-mail

Turning Point Treatment (For Staff Use Only)

Phase: _____ Director of Phase: _____

Case Manager: _____

Current Location/Residence: _____

Times of Availability: __ M-Th 9:30-11:00am (I) __ M-F 2:00-4:00pm (II)

__ Other: _____