THE BENEFIT OF

HOPE

DISCOVER HOPE | EMBRACE HEALING

This is an application for Voluntary Counseling Services to be provided at NO COST to the applicant. These services must be performed by one of the providers listed on the attached sheet. The applicant may choose any provider on the list. The following outlines the full application process:

1) Client will obtain application with provider list.
2) Client will choose a provider from the provider list.
3) Client will call to secure an initial appointment.
4) Provider will offer appointment times available within 2 weeks.
5) Client will attend the first appointment, with this **completed** application in hand.
6) Provider will complete the Initial Assessment and will make one of three recommendations:
    a. accept the client for counseling services,
    b. refer the client to another participating provider, or
    c. deem that counseling is not the beneficial course of action.
7) Provider will redact all grey highlighted areas and send a redacted copy to the Grant Liaison.

**IDENTIFICATION**

| | | |
|---|---|---|
| NAME:(first) | (middle init) | (last) |
| DOB: _____/_____/_____ | Age: | GENDER: MALE FEMALE |
| STREET ADDRESS: | | |
| CITY: | Tennessee | ZIP: |

**CONTACT**

| | |
|---|---|
| EMAIL ADDRESS: | May we Email you? Yes No |
| PRIMARY PHONE: | May we call/text/lvg vm? Yes No |
| SECONDARY PHONE: | May we call/text/lvg vm? Yes No |

**SCHOOL INFORMATION**

| | |
|---|---|
| SCHOOL NAME: | GRADE: |
| SCHOOL STRESSORS: | |

**EMERGENCY CONTACT INFORMATION**

| | | | |
|---|---|---|---|
| NAME: | RELATIONSHIP: | | PHONE: |
| STREET: | CITY: | ST: | ZIP: |

**THIS SECTION TO BE USED ONLY WHEN CLIENT IS A MINOR CHILD *(under 16 years old)***

**Biological parents are:** Married Separated Divorced Other **Child resides with (relationship):**

**Legal Guardian(relationship):**_____**County of Jurisdiction:** _____

**Parenting Plan?** _____Yes_____No **(*If yes, a copy is required by the next appointment*)**

**DCS Involvement?** __Yes __No **Previous Abuse Issues?** ___Yes____No **Circle all that apply:** Emotional Physical Sexual

THE BENEFIT OF

HOPE

DISCOVER HOPE | EMBRACE HEALING

**MENTAL HEALTH STATUS INFORMATION**

| How is your current emotional health? | Poor | Unsatisfactory | Satisfactory | Good | Very good |
|---|---|---|---|---|---|

| | | | |
|---|---|---|---|
| Abortion | Past and/or Present | Panic Attacks | Past and/or Present |
| Adoption | Past and/or Present | Paranoia/Overly Suspicious | Past and/or Present |
| Alcohol/Drug Use | Past and/or Present | Poor Memory | Past and/or Present |
| Anxiety | Past and/or Present | Racing Thoughts | Past and/or Present |
| Bedwetting | Past and/or Present | Rage/Anger | Past and/or Present |
| Body Image Issues | Past and/or Present | Repetitive Behaviors/Thoughts | Past and/or Present |
| Depression | Past and/or Present | Risky Behavior | Past and/or Present |
| Eating Issues | Past and/or Present | Sexual Dysfunction | Past and/or Present |
| Excitability | Past and/or Present | Sleep Disturbances | Past and/or Present |
| Extreme Mood Shifts | Past and/or Present | Social Shyness | Past and/or Present |
| Fatigue | Past and/or Present | Suicidal Attempts | Past and/or Present |
| Guilt/Shame | Past and/or Present | Suicidal Thoughts | Past and/or Present |
| Hallucinations | Past and/or Present | Stress | Past and/or Present |
| Harm to Self / Others / Animals | Past and/or Present | Unexplained losses of time | Past and/or Present |
| Headaches | Past and/or Present | Victim of Violence/Trauma | Past and/or Present |
| Impulsivity | Past and/or Present | Worthlessness | Past and/or Present |
| Nightmares | Past and/or Present | Other: | Past and/or Present |

Print Name of Client | Signature of Client (16 and older) or Legal Guardian (5-15) | Date

**COUNSELOR/THERAPIST USE ONLY**

Client approved for counseling (add'l 5 sessions) ? _____Yes _____NO

Sessions are scheduled at the following dates/times:

Session 1: Date_____ Time:_____

Session 2: Date_____ Time:_____

Session 3: Date_____ Time:_____

Session 4: Date_____ Time:_____

Session 5: Date_____ Time:_____

Session 6: Date_____ Time:_____

**Session 1 should be considered the Intake Session.

a) Referral made to:_____

_____

b) Counseling not recommended due to_____

_____

_____

_____

_____ _____

Signature of Counselor/Therapist, with credentials | Date