Child & Adolescent Psychiatry Consulting DBA

EMPOWER

MENTAL HEALTH CLINIC

empowermhc.com □ 2001 S. Central Ave. Ste. A, Marshfield, WI 54449 □ 715-384-2818

Request for Treatment Services: *In Your Own Words*

1. What concerns are bringing you to treatment?

2. What are your goals for treatment?

3. What will things be like if treatment is successful?

4. Describe the supports that you have and can depend upon during difficult or challenging times?

5. What strengths do you have that can help you with this difficult situation?

Client's Name (Print): _____

Client Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____