

TURNING POINT INTAKE SUMMARY

To be completed by psychiatrist, therapist, referring CPA, CPS worker or foster parent

Client's Name:		Date of Birth:				
Date:		Level of Care:	<input type="checkbox"/> Basic	<input type="checkbox"/> Intensive	<input type="checkbox"/> Moderate	<input type="checkbox"/> Specialized
Foster Parent:	Name:	Office Phone:				
	Address:	Cell Phone:				
	City	E-Mail:				
	State, Zip:	Fax:				
Legal Guardian:	Name:	Office Phone:				
	Address:	Cell Phone:				
	City	E-Mail:				
	State, Zip:	Fax:				
Attorney Ad Litem (GAL):	Name:	Office Phone:				
	Address:	Cell Phone:				
	City	E-Mail:				
	State, Zip:	Fax:				
CPA Worker	Name:	Office Phone:				
	Address:	Cell Phone:				
	City	E-Mail:				
	State, Zip:	Fax:				
DFPS Worker	Name:	Office Phone:				
	Address:	Cell Phone:				
	City	E-Mail:				
	State, Zip:	Fax:				
DFPS Supervisor	Name:	Office Phone:				
	Address:	Cell Phone:				
	City	E-Mail:				
	State, Zip:	Fax:				
Primary Care Physician	Name:	Office Phone:				
	Address:	Cell Phone:				
	City	E-Mail:				
	State, Zip:	Fax:				
On-Going Therapist:	Name:	Office Phone:				
	Address:	City, State, Zip:				

On-Going Psychiatrist:	Name:	Office Phone
	Address:	City, State, Zip:

1. Emergency contact (name & phone #):

2. Medical issues (Acute and Chronic):

3. Allergies (food, medication, etc.) or foods to avoid:

4. Does the client have any special dietary needs? If Yes No Unknown
yes, please explain:

5. Any restricted activity?

Medications/ Prescriptions	Medication Name	Reason for taking medicine	Dosage	Frequency	

Turning Point Staff name and signature

Date