Kris Brightbill, MA, LPC, NCC

484-319-1334 • turningtidestransitions@gmail.com • turningtidestransitions.com

TURNING tides TRANSITIONS

INTAKE FORM

Client Name: _____

Date of Birth: _____

Address, City/State: _____

Cell Phone: _____**Email address:** _____

Referred to Kris Brightbill/Turning Tides transitions by: _____

Emergency Contact Person

Name: _____ **Relationship to Client:** _____

Cell Phone #: _____

Email address: _____

Current Medications:

Name of Medication	Dose and Frequency	Prescribed By

Current Psychiatrist Name: _____ **Phone:** _____

Current Primary Care Physician Name: _____ **Phone:** _____

Current Impairments: Scale 0=none, 1=mild, 2=moderate, 3=severe

0 1 2 3 Mood Disturbance (Depression or mania)
0 1 2 3 Anxiety
0 1 2 3 Psychosis
0 1 2 3 Thinking/Cognition/Memory
0 1 2 3 Impulsive/Reckless/Aggressive
0 1 2 3 Activities of Daily Living
0 1 2 3 Weight Change - □Gain □ Loss
0 1 2 3 Medical/Physical Condition(s):_____
0 1 2 3 Substance Abuse/Dependent
0 1 2 3 Job/School Performance
0 1 2 3 Social/Marital/Family Problems
0 1 2 3 Legal: (please explain) _____

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Mental Health Treatment History- *(please check all that apply)*

☐ **Out-Patient Therapy -***If "Out-Patient Therapy" is checked, please indicate:*

Outcome: ☐Unknown ☐Improved ☐ No Change ☐ Worse

Treatment compliance (non-med): ☐ Unknown ☐Poor ☐ Fair ☐Good

Treatment Length *(dates)*: _____

Name of Program: _____ **Location:** _____

☐ **Intensive Out-Patient (IOP) /Partial**- *If "IOP/Partial" is checked, please indicate:*

Outcome: ☐Unknown ☐Improved ☐ No Change ☐ Worse

Treatment compliance (non-med): ☐ Unknown ☐Poor ☐ Fair ☐Good

Treatment Length *(dates)*: _____

Name of Program: _____ **Location:** _____

☐ **Inpatient/Residential/Group Home -** *If "Inpatient/Residential" is checked, please indicate:*

Outcome: ☐Unknown ☐Improved ☐ No Change ☐ Worse

Treatment compliance (non-med): ☐ Unknown ☐Poor ☐ Fair ☐Good

Treatment Length *(dates)*: _____

Name of Program: _____ **Location:** _____

☐ **Psychiatric hospitalization(s) -** *If Psychiatric Hospitalizations" is checked, please indicate:*

Outcome: ☐Unknown ☐Improved ☐ No Change ☐ Worse

Treatment compliance (non-med): ☐ Unknown ☐Poor ☐ Fair ☐Good

Number of Psychiatric hospitalizations: _____ **Number of hospitalizations in the past 12 months:** ____
Location(s): _____ **Length of Each Stay:** _____

***Please provide to clinical team any psychological testing and/or assessments that have completed for client.**

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Substance Abuse Treatment History: *(Please check all that apply)*

☐ **Intensive Out-Patient (IOP) /Partial**- *If "IOP/Partial" is checked, please indicate:*

Outcome: ☐Unknown ☐Improved ☐ No Change ☐ Worse

Treatment compliance (non-med): ☐ Unknown ☐Poor ☐ Fair ☐Good

Treatment Length *(dates)*: _____

Name of Program(s): _____ **Location(s):** _____

☐ **Inpatient/Residential/Group Home -** *If "Inpatient/Residential" is checked, please indicate:*

Outcome: ☐Unknown ☐Improved ☐ No Change ☐ Worse

Treatment compliance (non-med): ☐ Unknown ☐Poor ☐ Fair ☐Good

Treatment Length *(dates)*: _____

Name of Program: _____ **Location:** _____

Number of Psychiatric hospitalizations: _____ **Number of hospitalizations in the past 12 months:** ____
Location(s): _____ **Length of Each Stay:** _____

To be completed by clinical team:

DSM-IV Diagnosis:

Axis I 1) _____ 2) _____
Axis II: 1) _____ 2) _____
Axis III: 1) _____ 2) _____
Axis IV: _____
Axis V: Current GAF: _____ Highest GAF prev. year: _____