INTAKE REQUEST FORM

Date of Request: _____

Client's Name: _____

Client's Date of Birth_____/_____/_____ **Age: ____ Sex: □ male □ female □ transgender**

Home Address_____

City/Town _____ **State** _____ **Zip** _____

Is the client willing to attend? □ yes □ no □ unsure

Referred by: _____ Phone: _____

Relationship to client: _____

Parent/Guardian Name: _____

Phone: _____ Email: _____

INSURANCE: □ Aetna □ Anthem/BCBS of _____ □ Beacon □ Cigna
□ Harvard Pilgrim □ United Healthcare □ Health Plans □ MassHealth (MBHP only)
□ Oxford Health Plans □ Tufts □ Neighborhood Health Plans / Allways □ Well Sense
□ Unicare □ Other: _____

PRIMARY INSURANCE ID #_____

Subscriber's Name _____

Subscriber's Birthdate _____/_____/_____Insurance Phone: _____

Subscriber's Address: _____

SECONDARY INSURANCE ID #_____

Subscriber's Name _____

Subscriber's Birthdate_____/_____/_____ Insurance Phone: _____

Subscriber's Address: _____

Please Fax to 603-760-1949

Currently Hospitalized? □ YES □ NO If Yes, Where?_____

Discharge Date: :____/_____/_____ Eval or discharge forms faxed to us? □YES □ NO

CURRENT CHIEF COMPLAINTS (Check all that apply and add comments below)

□ anxiety □ panic attacks □ OCD □ depression □ suicidal ideation □ suicide attempt

□ self harm □ psychosis □ trauma/PTSD □ grief/loss □ mood instability □ behavior issues

□ gender/sexual orientation issues □ ADHD □ learning disabilities □ school refusal

□ *violent behavior (e.g., aggression, stalking, sexual predation) □ *substance use

□ *autism spectrum disorder □ *MR; developmental issues □ *eating disorder

Other Clinical Notes (providers, please attach additional clinical if needed):

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Please Fax to 603-760-1949