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: _________________________________

<u>INSURANCE</u>: ☐ 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 ☐ *intellectual or developmental disability ☐ *eating disorder

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

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Please Fax to 603-760-1949