ENDURANCE
BEHAVIORAL HEALTH PLLC

Re-Intake Form

Client Name:_____

Address: _____

Insurance Carrier: _____ Policy ID #: _____

Who referred you back to Endurance? _____

For what reason? _____

Have you had a recent crisis evaluation? ☐YES ☐NO

If yes, where: _____ Date: _____

Reason: _____

What is your current living arrangement? _____
_____

Presenting problem/reason for re-admission:
_____
_____
_____
_____
_____

Are you currently or have you ever experienced any of the following:

Hallucinations: ☐None ☐Auditory ☐Visual ☐Other:

Other: ☐Derealization ☐Depersonalization ☐ Dissociation

Re-Intake Form (Page 2)

Are you currently experiencing impairment with any of the following:

☐ Significant Functional Impairment

- ☐ Activities of Daily Living (ie. showering, brushing teeth)
- ☐ Social/Emotional
- ☐ Academic/Vocational
- ☐ Medical/health

☐ Other (specify):

Please provide any additional information:

_____
_____
_____

Treatment History:

Below, please list any inpatient hospitalizations, residential treatment, or other psychiatric admissions since you were last treated at Endurance:

Dates of Admission	Facility Name	Reason for Admission

Re-Intake Form (Page 3)

Outpatient Providers:

Current outpatient psychiatric prescriber: _____

Current outpatient therapist: _____

Primary Care Physician (PCP): _____

School: _____ Grade: _____

School Contact (e.g., guidance counselor): _____

School Status: ☐Attending ☐Medical Leave ☐Pending

MEDICATIONS

Below, please list ALL current medications (psychiatric, non-psychiatric, supplements, etc.)

Medication Name	Dose	Time	On What Date Did You Start **This Dose**?	Who **Currently** Prescribes This Medication?
		AM☐ PM☐ Other☐_____		
		AM☐ PM☐ Other☐_____		
		AM☐ PM☐ Other☐_____		
		AM☐ PM☐ Other☐_____		
		AM☐ PM☐ Other☐_____		
		AM☐ PM☐ Other☐_____		
		AM☐ PM☐ Other☐_____		