ENDURANCE BEHAVIORAL HEALTH INTAKE REQUEST FORM

Parent/Guardian must call after this form is sent in to start the intake process.

Call (603) 760-1942 x309. Please use black ink and write legibly.

Date:/	
Willing to attend? yes no unsure	(Choose One) In-Person Virtual
Referred by:	Relationship to client
CLIENT INFORMATION ONLY: *Please do r	ot put parent/guardian's info in this section.*
Legal Name: First	Last
Chosen name (if applicable)	
Date of Birth//Age:	Sex:Male FemaleIntersex
Gender:MaleFemaleNonbinaryO	her:
Home Address	
City/Town	_StateZip Code
Cell Phone: () Email:_	
PARENT/GUARDIAN INFORMATION	
*Parents TogetherYN *Parental C	ustody IssuesYN If yes explain on the back
Parent/Guardian 1 Name: First	Last
Cell Phone: ()Er	nail:
Parent/Guardian 2 Name: First	Last
Cell Phone: ()Er	nail:
INSURANCE:Aetna Amerihealth Ca	ritasAnthem/BCBS of
CignaFallonGICHarvard Pilgri	mHealth Plans
Mass General Brigham (formerly AllWays)	MassHealth (MBHP only) Meritain
NH Healthy FamiliesOxford Health Pla	nTufts (commercial only)Unicare
United HealthcareNH Well Sense0	Other:
PRIMARY INSURANCE ID #	Group #
Subscriber's Name	
Subscriber's Birthdate//I	nsurance Phone ()
2nd INSURANCE ID #	_ Group #
Subscriber's Name	
Subscriber's Birthdate//	Insurance Phone ()
OFFICE USE ONLY: Date Checked	Checked by Eligibility Verified Y / N

Client currently hospitalized? Y N If Yes, Where?		
Discharge date: Crisis evaluation or discharge forms faxed to us?Y N		
CURRENT CHIEF COMPLAINTS (Check all that apply and add comments below)		
anxietypanic attacksOCDdepressionsuicidal ideationsuicide attempt		
self harmpsychosistrauma/PTSDgrief/lossmood instabilitybehavior issues		
gender/sexual orientation issuesADHDlearning disabilitiesschool refusal		
*violent behavior (e.g., aggression, stalking, sexual predation)*substance use		
*autism spectrum disorder*intellectual or developmental disability*eating disorder		
Other Clinical Notes: (Provide a brief description and attach additional notes if needed.)		