

INTAKE REQUEST FORM

Date of Request//	_	
Client's Name:		
Client's Date of Birth//	Age: Sex:r	malefemaleintersex
Gender:malefemalenonbin	aryother:	
Home Address		
City/Town	State	Zip
Is the client willing to attend?yes	nounsure	
Referred by:	Phone:	
Relationship to client:		
Parent/Guardian Name:		
Phone: Er	mail:	
INSURANCE:AetnaAnthem/Bo Harvard PilgrimUnited Healthcare Oxford Health PlansTuftsNe UnicareOther:	eHealth PlansMassH eighborhood Health Plans / All	ealth (MBHP only)
PRIMARY INSURANCE ID #	Group#	<u> </u>
Subscriber's Name		
Subscriber's Birthdate//	Insurance Phone:	
SECONDARY INSURANCE ID #	Group#_	
Subscriber's Name		
Subscriber's Birthdate//	Insurance Phone:	

Currently Hospitalized?YESNC	Olf Yes, Where?
Discharge Date:	Eval or discharge forms faxed to us?YESNO
CURRENT CHIEF COMPLAINTS (CI	neck all that apply and add comments below)
anxietypanic attacksOCD _	depressionsuicidal ideationsuicide attempt
self harmpsychosistrauma/P	PTSDgrief/lossmood instabilitybehavior issues
gender/sexual orientation issues _	_ADHDlearning disabilitiesschool refusal
*violent behavior (e.g., aggression,	stalking, sexual predation)*substance use
*autism spectrum disorder*intel	lectual or developmental disability*eating disorder
Other Clinical Notes (providers, pleas	e attach additional clinical if needed):