ENDURANCE
BEHAVIORAL HEALTH PLLC
P.O. Box 2899, 823 Lafayette Rd.
Seabrook, New Hampshire 03874
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endurancebehavioralhealth.com

Re-Intake Request Form

Client Name: _____ Date of Birth: _____

Seeking re-intake to ___ PHP ___ IOP. Will attend ___ in-person ___ virtually ___ hybrid

Has your contact information and/or insurance changed? ___Yes ___No **(If Yes, update below)**

Contact Information

Home Address: _____

Client's Cell Phone: _____ Client's Email:_____

Parent/Guardian 1 Name: _____

Cell Phone: _____ Email: _____

Parent/Guardian 2 Name: _____

Cell Phone: _____ Email: _____

What is the client's current living arrangement?

_____

Insurance

Primary Insurance Carrier: _____ Policy ID #: _____

Secondary Insurance Carrier: _____ Policy ID #: _____

Clinical Information

Presenting problem/reason for re-admission:

_____

_____

Who referred you back to Endurance? _____

Re-Intake Form (Page 2)

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

If yes, where: _____ Date: _____

Reason: _____

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

Hallucinations: ☐ None ☐ Auditory ☐ Visual ☐ Other:

Other: ☐ Derealization ☐ Depersonalization ☐ Dissociation

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: _____

<u>Treatment History</u>: Below, please list any inpatient hospitalizations, residential treatment, or other psychiatric admissions <u>since you were last treated at Endurance</u>:

Dates of Admission	Facility Name	Reason for Admission

Current Outpatient Providers:

Psychiatric medication prescriber: _____

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 ☐ _____		