Stepping Stones to Well Being, LLC
131 B Main Street Epping, NH 03402
Fax: 603-218-6990
Email: info@stepping-stones-2-wellbeing.com

**Please note that the most efficient way to contact the office is through email.**
Please complete this intake form and return via fax, email or USPS. Once this packet is received and reviewed an intake appointment can be scheduled.

Today's Date: _____ Referred By: _____

Patient Full Legal Name: _____ Date of Birth: _____

Preferred Name: _____

Address: _____

Primary Phone Number: _____ Other Phone Number: _____

Email Address: _____

Marital Status: _____ Preferred Pronouns: _____ Gender: _____

Sexual Orientation: _____ Race: _____ Ethnicity: _____

Employment Status: _____ **OR** Current College & Year: _____

## For Those Under 18

School: _____ Grade: _____

Parent/Guardian Name: _____

Address: _____ (if different than above)

Phone: _____

Email: _____

Custody: _____

Please note if parents are divorced and there is a parenting plan or if there are other court documents specifying decision making these MUST be provided to the office before medication can be prescribed

**INSURANCE INFORMATION - Please provide a copy of the card front and back**

Primary Insurance Name: _____

Policy/ID #: _____ Group #: _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to the Patient: _____ Phone: _____

Address (City, State & Zip if different than above): _____

Secondary Insurance Name: _____

Policy/ID #: _____ Group #: _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to the Patient: _____ Phone: _____

Address (City, State & Zip if different than above): _____

**EMERGENCY CONTACT INFORMATION**

Name: _____ Relationship: _____

Phone: _____ Email: _____

☐ By checking this box, I am agreeing that in case of emergency this person can be notified that I am receiving services with Stepping Stones to Wellbeing, LLC and that if there is an emergency that Stepping Stones to Well Being, LLC can contact this person for a check in or notify them of any safety concerns.

**Are there any immediate safety concerns? (Harm to self/others/running away/aggression that results in harm to self/others)**

_____

Are there weapons in the home? If so how are they secured? _____

_____

Are there any specific schedule restrictions or other factors that are important to know (i.e. specific religious celebrations, cultural needs)? _____

_____

Are there any issues that prevent you from using telehealth (Zoom) for appointments? _____

_____

Do you have any history of trauma surrounding dogs? This is important as there are dogs in the office location at times. _____

***HEALTH HISTORY***

*Current PCP:* _____
*Last Height, Weight, Blood Pressure, and Pulse:* _____
*Last Physical:* _____

If you have had bloodwork in the past year please provide. If you have not, this may be necessary before medication can be prescribed.

*Pharmacy:* _____

**Please list any medical hospitalizations that you have had:** _____

_____

**Allergies**

Food: _____

Medication: _____

Environmental: _____

**Nutritional/Health Information:**

Are there any special diets/nutritional regimen's that you follow? _____

How many meals do you typically eat in a day? _____

What types of physical activity do you engage in and how often? _____

_____

Are you currently working with a Nutritionist/Dietician? _____

**Surgical History:**

Please list any surgeries that you have had and the dates: _____

_____

_____

**For female clients:**

Are you currently pregnant or thinking of becoming pregnant? _____

Are you undergoing any IVF or other treatment for pregnancy? _____

Are you currently taking any Oral Contraceptives? _____

Are you currently breastfeeding? _____

Last menstrual cycle: _____

**MEDICAL HISTORY:**

**If there is no history, you can leave it blank**

Please use the following for indication of family relation:
**Sibling = Sb, Grandmother = GM, Grandfather = GF, Aunt = A, Uncle = U, Cousin = C**

| Diagnosis | Self | Maternal | Paternal | Information |
|---|---|---|---|---|
| Anemia (Iron, Pernicious, etc.) | | | | |
| Aneurysm | | | | |
| Arterial Disorder (Peripheral, Arterial, Pulmonary) | | | | |
| Arthritis | | | | |
| Asthma/Bronchitis | | | | |
| Bladder/Kidney Issues | | | | |
| Cancers (Please note Type) | | | | |
| Celiac Disease | | | | |
| Cerebral Palsy | | | | |
| Concussion/Head Injury | | | | |

| Diagnosis | Self | Maternal | Paternal | Information |
|---|---|---|---|---|
| Connective Tissue Disorder | | | | |
| COPD/Emphysema | | | | |
| COVID | | | | |
| Diabetes (I Or II) | | | | |
| Eczema | | | | |
| Ehlers-Danlos | | | | |
| Epilepsy/Seizure | | | | |
| Epstein-Barr Virus | | | | |
| Eye/Vision Issues | | | | |
| Fainting | | | | |
| Fibromyalgia | | | | |
| Hearing Loss | | | | |
| Heart Attack (please note age) | | | | |
| Heartburn/GERD | | | | |
| Hemophilia | | | | |
| High Blood Pressure | | | | |
| High Cholesterol | | | | |
| Hypermobility Syndrome | | | | |
| Kawasaki Disease | | | | |
| Kidney Disease | | | | |
| Liver Disease (Hepatitis, Fatty Liver, Cirrhosis) | | | | |
| Lupus | | | | |
| Lyme Disease Other Tick Born Illness | | | | |
| Meningitis | | | | |
| Migraines | | | | |
| Multiple Sclerosis | | | | |
| Osteoarthritis | | | | |
| PANS/PANDAS | | | | |
| PCOS | | | | |
| Pneumonia | | | | |
| POTS | | | | |
| Psoriasis | | | | |
| Repeated Strep Throat | | | | |
| Restless Leg | | | | |
| Scarlett Fever | | | | |
| Shingles | | | | |
| Stomach/Bowel Issues (Please note which type) | | | | |

| Diagnosis | Self | Maternal | Paternal | Information |
|---|---|---|---|---|
| Stroke | | | | |
| Thalassemia | | | | |
| Thyroid Disorder (please note type) | | | | |
| Toxin Exposure (Mold etc.) | | | | |
| Vitamin Deficiency | | | | |
| Vitiligo | | | | |
| Von Willebrand | | | | |
| Other | | | | |

***Additional Health Information:*** _____

_____

## Family & Personal Mental Health History

**Please provide the following information:**

*Current Therapist & Frequency:* _____

*Previous Therapist:* _____

*Do you currently have a psychopharmacology prescriber?* _____

*Current Psychopharmacology Prescriber:* _____

*If you are transferring to this practice, please share why and does the provider know that you are transferring:*

_____

**If there is no history, you can leave it blank**

Please use the following for indication of family relation:
**Sibling = Sb, Grandmother = GM, Grandfather = GF, Aunt = A, Uncle = U, Cousin = C**

| Diagnosis | Self | Maternal | Paternal | Information |
|---|---|---|---|---|
| ADHD (please note age of diagnosis) | | | | |
| Agoraphobia | | | | |
| Alzheimer's Disease | | | | |
| Anorexia Binge-Purge Type | | | | |
| Anorexia Restricting | | | | |
| Anxiety | | | | |
| ARFID | | | | |
| Autism Spectrum Disorder | | | | |

| Diagnosis | Self | Maternal | Paternal | Information |
|---|---|---|---|---|
| Binge Eating Disorder | | | | |
| Bipolar Disorder (note I or II) | | | | |
| Borderline Personality Disorder | | | | |
| Depression | | | | |
| Disruptive Mood Dysregulation Disorder | | | | |
| Gambling Disorder | | | | |
| Gender Identity | | | | |
| Hoarding Disorder | | | | |
| Hypersomnia | | | | |
| Insomnia | | | | |
| Learning or Other Processing Disorder | | | | |
| Non-Verbal Learning Disorder | | | | |
| Obsessive Compulsive Disorder | | | | |
| Oppositional Defiant Disorder | | | | |
| Other Personality Disorder | | | | |
| Panic Disorder | | | | |
| Parkinson's Disease | | | | |
| PMDD | | | | |
| Postpartum Anxiety | | | | |
| Postpartum Depression | | | | |
| PTSD | | | | |
| Reactive or Other Attachment Disorder | | | | |
| Schizophrenia | | | | |
| Separation Anxiety Disorder | | | | |

| Diagnosis | Self | Maternal | Paternal | Information |
|---|---|---|---|---|
| Substance Use Disorder (please note type) | | | | |
| Tourette's Disorder | | | | |
| Other | | | | |

Is there any family history of completed or attempted suicides? If yes, please indicate family relation.

_____

**Please list any psychiatric hospitalizations that you have had**

| Location | Reason | When |
|---|---|---|
| | | |
| | | |
| | | |

## Current Medication List

*Please complete the following and include medications you may be taking at this time* ***(for medical and mental health related diagnoses****). **Please include any herbs, supplements or other over the counter things you are taking**.*

| Name | Dosage | Prescriber | Any reactions |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**PREVIOUS MEDICATIONS**

| Name | Dosage | Negative/Adverse reactions |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Is there any additional information that is important to know in working with you: _____

_____

_____

_____

Thank you for your time in completing this lengthy history.

Stepping Stones to Well Being, LLC
131 B Main Street Epping, NH 03402
**Fax:** 603-218-6990 **Email:** info@stepping-stones-2-wellbeing.com

**Please note that the most efficient way to contact the office is through email.**

Client name: _____ DOB: _____

## Global Consent to Treatment

An important part of treatment, regardless of the proposed intervention or discipline, is that both parties understand and agree that they are working together. Part of working together is an understanding that all services received through Stepping Stones to Well Being, LLC. are voluntary and are able to be discontinued/terminated at any time in the future.

Additionally, as part of appropriate, individualized, comprehensive, and professional care I sign with the understanding that all treatment plans/interventions are created with an explanation and review of the potential risks, benefits and alternatives to treatment that are available. By initialing next to each policy, I am verifying that I have read and understood the various policies and procedures as they pertain to services.

____ Program Information including (Philosophy, Client Commitment and Reason for Discharge)

____ Patient's Rights

____ Medical Monitoring and Coordination of Care

____ Attendance Policy and Missed Appointments

____ Telepsychiatry Appointments

____ Financial Responsibility Policy

____ Prescription and Schedule II & IV Medications

____ Prescription Information (including Prior Authorizations, Refills, and Medication Changes)

____ Treatment Planning & Compliance

____ Therapeutic Intervention, Availability & Scheduling

***By providing the electronic signature above, the individual agrees that the electronic signature is the legal equivalent of a manual signature.***

Client/Guardian Signature: _____
Date: _____

Stepping Stones to Well Being, LLC

**Fax:** *603-218-6990* **Mailing Address:** *131 Main Street Epping, NH 03042*

Patient Name _____ DOB: _____

Address: _____

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I hereby request and authorize Stepping Stones to Well-Being, LLC. to (please check the appropriate box)

_____ Receive From _____ Exchange With _____ Provide To

Name/Address/Phone/Fax:_____

_____

**Please use another page for additional providers – this is for ONE provider only**

The purpose of this release is for: ☐ Coordination of Care ☐ Transition of Care

Information to be released in written or oral form (Please Check):

| | | | |
|---|---|---|---|
| ☐ | Initial Evaluation | ☐ | Medical History |
| ☐ | Recent Lab Work | ☐ | Treatment Summary |
| ☐ | Diagnosis | ☐ | Current Medications |
| ☐ | Hospital Discharge Summary | ☐ | Psychological Testing |
| ☐ | IEP/504 Plan | ☐ | Appointment Times/Attendance |
| ☐ | Other | ☐ | Other |

If my initials appear here _____, I specifically authorize release of drug, alcohol abuse, sexually transmitted disease and/or counseling/psychiatric records. I understand that my drug treatment records are protected by under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, Subpart C and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

If my initials appear here _____, I specifically authorize release of my records that contain information about my HIV diagnosis, tests or treatment of HIV and AIDS, and which may contain reference to my identity as HIV positive or as an AIDS patient.

I have carefully read and understand the above statements, and voluntarily consent to disclosure of the above information about, or medical records of my condition to those persons of agencies named above. I understand this authorization may be revoked at any time. Revocation must be made in writing.

This authorization will expire at the termination of treatment unless revoked prior to termination of treatment.

***By providing the electronic signature above, the individual agrees that the electronic signature is the legal equivalent of a manual signature.***

_____ _____

Client/Guardian Signature Date