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 is received and reviewed an intake appointment can be scheduled.

Today's Date: _____ Referred By: _____

Patient Full Name: _____ Date of Birth: _____

Address: _____

Primary Phone: _____ Other Phone: _____

Email Address: _____

Marital Status: _____ Preferred Pronouns: _____ Gender: _____

Sexual Orientation: _____

Race: _____ Ethnicity: _____

Employment Status: _____

School: _____ Grade: _____

For those under 18:

Parent/Guardian Name: _____ Date of Birth: _____

Relationship to the Patient: _____

Address (if different): _____

Phone #: _____ Email: _____

Custody: _____

Insurance: (A copy of your insurance card front and back is required)

Patient's Primary Insurance Carrier (Plan Name): _____

Policy #/ID #: _____ Group #: _____

Name of Policy Holder: _____ Date of Birth: _____

Relationship to the Patient: _____ Phone #: _____

Address: _____

Patient's Secondary Insurance Carrier: _____

Policy #/ID #: _____ Group #: _____

Name of Policy Holder: _____ Date of Birth: _____

Relationship to the Patient: _____ Phone #: _____

Address: _____

Emergency Contact:

Name: _____ Relation: _____

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 not*** had a physical in the last year, you will need to have blood work drawn to ensure your overall health before medications can be safely prescribed*

*If you ***HAVE*** had a physical in the past year, please have a copy of your most recent blood work and physical sent to the office*

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? _____

Is there any additional information that would be helpful/important to know about your overall physical health?

_____

_____

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:

Family and personal health history (You can just indicate next to the condition – you do NOT need Y/N for each issue) ***For Grandparent and Aunts and Uncles please indicate P for Paternal and M for Maternal***

	Self	Mother	Father	Grandparent	Sibling	Aunt/Uncle	**When/Type**
Anemia							
Aneurysm							
Arterial Disorder (Peripheral, Arterial, Pulmonary)							
Arthritis							
Asthma/Bronchitis							
Bladder/Kidney Issues							

	Self	Mother	Father	Grandparent	Sibling	Aunt/Uncle	**When/Type**
Blood Issues (i.e. Hemophilia, Thalassemia, Sickle Cell, Von Willebrand)							
Broken Bones/Fractures							
Cancers (please note what type of cancer)							
Celiac Disease							
Cerebral Palsy							
Connective Tissue Disorder							
COPD/Emphysema							
COVID							
Diabetes (note type)							
Eczema							
Ehlers-Danlos Syndrome							
Epilepsy or Seizures							
Epstein-Barr Virus							
Eye/Vision Issues							
Fainting							
Fibromyalgia							
Head Injury (TBI, Concussion, etc.)							
Hearing Loss							
Heart Attack							
Heartburn/GERD							
High Blood Pressure							
High Cholesterol							
Kawasaki Disease							
Kidney Disease							
Liver Disease/Hepatitis							
Lupus							
Lyme Disease/Other Tick Born Illness							
Meningitis							
Migraines							
Multiple Sclerosis							
Osteoarthritis							
Other (please note)							
PANDAS/PANS							
PCOS							
Pneumonia							
Psoriasis							
Repeated Strep Throat							
Scarlett Fever							
Shingles							

	Self	Mother	Father	Grandparent	Sibling	Aunt/Uncle	**When/Type**
Stomach/Bowel Issues (i.e. IBS)							
Stroke							
Thyroid Disorder (please specify)							
Toxin Exposure (Mold etc.)							
Vitamin Deficiencies (please specify)							
Vitiligo							

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:

_____

Please use the same notations as above in the medical section (M = Maternal P = Paternal)

	Self	Mother	Father	Grandparent	Sibling	Aunt/Uncle
ADHD						
Agoraphobia						
Alzheimer's Disease						
Anorexia Nervosa Binge-Purge Type						
Anorexia Restricting Type						
Anxiety						
Autism Spectrum Disorder						
Binge Eating Disorder						
Bipolar Disorder						
Borderline Personality or other Personality Disorder						
Depression						

	Self	Mother	Father	Grandparent	Sibling	Aunt/Uncle
Disruptive Mood Dysregulation Disorder						
Gambling Disorder						
Gender Identity/Dysphoria						
Hoarding Disorder						
Insomnia or Hypersomnia						
Learning/Processing Disorder						
Non-Verbal Learning Disorder						
Obsessive Compulsive Disorder						
Oppositional Defiant Disorder						
Panic Attacks						
Parkinson's Disease						
PMDD						
Postpartum Depression/Anxiety						
PTSD						
Reactive or Other Attachment Disorder						
Schizophrenia						
Separation Anxiety Disorder						
Substance Use Disorder (Alcohol etc.)						
Tourette's Disorder						

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

_____

Please list any psychiatric hospitalizations

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. It is a lot of information but will be helpful in working together!

Updated: 7/1/22

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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: all treatment plans, regardless of if they are for psychopharmacology intervention or individual therapy, 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

Client/Guardian Signature: _____
Date: _____

Stepping Stones to Well Being, LLC

This release is for ONE provider. By law written permission is required to release your medical information:

Patient Name _____ DOB: _____

Address: _____

I hereby request and authorize Stepping Stones to Well-Being, LLC. to (please check the appropriate box)
____ Exchange With ____ Receive From ____ Provide to/with
Name/Address/Phone/Fax:_____

_____

Please use another page for additional providers

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.

_____ _____

Client/Guardian Signature Date

_____ _____

Witness Date