Stepping Stones to Well Being, LLC
131 B Main Street Epping, NH 03402
Fax: 603-218-6990
Email: info.sstwb@gmail.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 Legal Name: _____ Date of Birth: _____

Preferred Name: _____

Address (City, State & Zip): _____

Primary Phone: _____ Other Phone: _____

Email Address: _____

Gender: _____ Marital Status: _____

Sexual Orientation: _____ Race: _____ Ethnicity: _____

Employment Status: _____

School: _____ Grade: _____

FOR THOSE UNDER THE AGE OF 18 (Please note if parents are divorced and there is a parenting plan, this needs to be provided to the office. If parents share custody, both must consent to medication.)

Parent/Guardian Name: _____ Date of Birth: _____

Address (if different than above): _____

Phone #: _____

Email: _____

Custody: _____

Insurance: (A copy of your insurance card front and back is required)
Primary Insurance Carrier Plan Name: _____
Policy/ID #: _____ **Group #:** _____
Name of Policy Holder: _____ **Date of Birth:** _____
Relationship to the Patient: _____ **Phone #:** _____
Address: _____

Secondary Insurance Carrier Plan Name: _____
Policy/ID #: _____ **Group #:** _____
Name of Policy Holder: _____ **Date of Birth:** _____
Relationship to the Patient: _____ **Phone #:** _____
Address: _____

Emergency Contact:

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 not*** had a physical in the last year, you may 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: _____

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: _____

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:

_____

Are there other providers you are working with (i.e. marriage counseling, Occupational Therapy, Speech Therapy, etc.)

_____

_____

MEDICAL & MENTAL HEALTH HISTORY:

If there is no history, you can leave it blank

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

Medical Issue	Self	Maternal	Paternal	Sibling	Child	Information
Anemia (please note Iron or Pernicious)						
Aneurysm						
Arterial Disorder (Peripheral, Arterial, Pulmonary)						
Arthritis						
Asthma/Bronchitis						
Bladder/Kidney Issues						
Broken Bones/Fractures						
Cancers (please note what type of cancer)						
Celiac Disease						
Cerebral Palsy						
Chronic Pain						
Concussion or other Head Injury						
Connective Tissue Disorder						
COPD/Emphysema						
COVID						
Diabetes (I or II)						
Eczema						
Ehlers-Danlos Syndrome						
Epilepsy or Seizures						
Epstein-Barr Virus						
Eye/Vision Issues						

Medical Issue	Self	Maternal	Paternal	Sibling	Child	Information
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						
Lupus						
Lyme Disease/Other Tick Born Illness						
Meningitis						
Migraines						
Multiple Sclerosis						
Osteoarthritis						
PANDAS/PANS						
PCOS						
Pneumonia						
Psoriasis						
Repeated Strep Throat						
Scarlett Fever						
Shingles						
Stomach/Bowel Issues (i.e. IBS)						
Stroke						
Thalassemia						
Thyroid Disorder (please specify)						

Medical Issue	Self	Maternal	Paternal	Sibling	Child	Information
Toxin Exposure (Mold etc.)						
Vitamin Deficiencies (please specify)						
Vitiligo						
Von Willebrand						
Other						
Other						
Other						
Other						

Please list any psychiatric hospitalizations that you have had

Location	Reason	When

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

If there is no history, you can leave it blank

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

Diagnosis	Self	Maternal	Paternal	Sibling	Child	Information
ADHD (please note age of diagnosis)						
Agoraphobia						
Alzheimer's Disease						
Anorexia Binge-Purge						

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

Diagnosis	Self	Maternal	Paternal	Sibling	Child	Information
Separation Anxiety Disorder						
Substance Use Disorder (Please note Substance – Alcohol, etc.)						
Tic Disorder						
Tourette's Disorder						
Other						
Other						
Other						

Medication List

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

Name	Dosage	Prescriber	Current (Y or N)	Any reactions

Name	Dosage	Prescriber	Current (Y or N)	Any 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.

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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

Client/Guardian Signature: _____
Date: _____

Stepping Stones to Well Being, LLC

Fax: 603-218-6990

131 Main Street Epping, NH 03042

Patient Name _____ DOB: _____

Address: _____

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

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