



Intake Form

Client Information

Client Name:
Phone:

Referral Date:

DOB:
Email:

Insurance Information

- Be Healthy Partnership
- Blue Cross Shield of Massachussets
- Community Care Cooperative
- Health New England
- Mass General Brigham
- MBHP
- Partners HealthCare Choice
- PCC - Primary Care Clinician Plan
- Steward Health Choice
- Tufts Health
- Other:

Private:

MassHealth ID:
Member ID:
Benefit Year:

Copayment:
Number of sessions:

Person Completing Intake

- Client
- Family member:
- Other:
- Agency
- Agency Name:

Client Demographic

Current Address:

Apt #:
City:

State:
ZIP:

Name of Parent / Guardian: Relationship: Phone:
Name of Parent / Guardian: Relationship: Phone:





Intake Form

Marriage Status:

Legal Status of child:

Percentage of Parent's Guardianship:

Is the Parent/Guardian of youth aware and in agreement with this referral? Yes No

Emergency Contact:

Name:

Relationship:

Phone:

Preferred Language of Client:

English Portuguese

Preferred Language of Parent/Guardian:

English Portuguese

Does the client have any special communication needs? Yes No

Preference of session type: Virtual only In person only No preference

Clinical Information

Presenting issues and reasons for seeking services:

1) Does the person being referred know someone who receives services at Embrace? Yes No

If yes, name the Client and Clinician:

2) Has the person being referred had any recent psychiatric hospitalization? Yes No Not Sure

If yes, identify Date and Location:



3) Is the person being referred at risk of being hospitalized now? Yes No Not Sure

If yes, explain why:

4) Is the person being referred currently working with another Mental Health Provider?

Yes No Not Sure

5) Is the person being referred taking any prescribed psychiatric medication?

Yes No Not Sure

If yes, specify Dosage and Frequency:

6) Is the person being referred or the family, involved with DCF/DYS? Yes No Not Sure

PCP Information

Name of the client's Primary Care Physician:

Phone # of Primary Care Physician:

Fax # of Primary Care Physician:

Availability for Sessions

Day: Monday Tuesday Wednesday Thursday Friday Saturday

Time: AM PM

How did you know hear about us:

Google

Friend referral

Church

Facebook

Embrace's client

Other:

KGA

Psychology today

Name of Provider filling this form:





Intake Form

Administrative Use Only

Accepted for service. If not why?

Assigned provider:

Referred elsewhere.

Why:

Where:

Waiting list date:

Final disposition:

