Assigned Procentive Chart # _____

Adult Intake Form
COUNSELING SERVICES OF SOUTHERN MN

Date of Referral: _____ **Services Requested:** _____

Referred By: _____**Phone and Fax #**_____

Have you received services at CSSM in the past? _____

Legal Name: _____ _____ **Preferred Name:** _____

Birth Date: _____ **Social Security Number:** _____

Gender: □ Male □ Female □ Other (please specify): _____

Primary Phone: _____ □ Home □ Cell □Work

Email: _____

Mailing Address: _____

_____

Site Preference: □ St. Peter □ Mankato □ Either

Primary Language: □ English □ Spanish □ Arabic □ □ Sign Language

□ Sudanese □ Vietnamese □ Other: _____

Marital Status: □ Single/Never married □ Widowed □ Divorced/Remarried

□ Married/Separated □ Married/Living with spouse

Legal Guardian: □ Yes **Contact Information:** _____

Interpreter Needed: □ Yes □ No

Insurance:

- Primary Insurance: _____
  Group Number: _____ ID Number: _____
  Subscriber's Name: _____DOB: _____Relationship to Client: _____
- Secondary Insurance: _____
  Group Number: _____ ID Number: _____
  Subscriber's Name: _____DOB: _____Relationship to Client: _____

Billing Information/Contact- Send Statement To (if different from above):

- Name: _____
- Address: _____
- Phone Number: _____ Relationship to Client: _____

Current Services:

- Primary Care Provider: _____ Location: _____
- Therapist: _____ Location: _____
- Case Manager: _____ Location: _____
- Psychiatrist: _____ Location: _____
  (current medications: _____ _____ Location: _____

What are your presenting concerns or symptoms? What would you like your treatment focused on?

_____

_____

_____

_____

Do you identify with a specific culture, race, religion, gender identity or background that you would like us to be aware of for best treatment? _____

_____

Have you experienced something bad or upsetting that you cannot stop thinking about, or that disrupts your sleep or causes fear?_____

_____

Would you prefer a clinician with specialty in:

_____ LGBT **___ Couples Counseling**

_____ Substance Use Disorders **____ Parent-Child Therapy** **_____ Trauma**

FAX REFERRAL TO:
ATTN: INTAKE DEPT
FAX NO: 507-931-8060
Questions? PHONE NUMBER: 931-8040

Internal Use Only:

Intake Follow-up: Contact or Message Left on _____ No Message: No voice mail Mail box full Disconnected