Assigned Procentive Chart # ________________

Child Intake Form

COUNSELING SERVICES OF SOUTHERN MN

Date of Referral: __________________ **Services Requested:** ________________________

Referred By: ______________________________ **Phone and Fax #**________________________________

Has your child received services at CSSM in the past? _______________

Legal Name: ___________ _______________ **Preferred Name:** ___________________________

Birth Date: ___________________________ **Social Security Number:** ________________________

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

Parent/Guardian Name(s): _____________________ _____________________

Mailing Address: _________________________________

____

Site Preference:
□ St. Peter □ Mankato □ Either

Primary Phone: _____________________ □ Home □ Cell □Work

Email: ____________________

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

□ Married/Separated □ Married/Living with spouse

Joint Parent Address & Phone Number:

____

____

Custody Arrangement: **Sole** **Joint**

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: ______________________
  - Medications:

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

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

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Trauma Screener Questions- the purpose of these questions is to fit your child with the best therapist that will provide the most effective treatment.

1. Does your child seem excessively fearful or worried? (i.e. clingy behavior, afraid to leave caregiver or home, fear of the dark or loud noises, etc.)
   a. No b. Yes, explain:
2. Does your child experience difficulty sleeping? (i.e. fear of going to sleep, trouble falling or staying asleep, nightmares, etc.)
   a. No b. Yes, explain:
3. Has your child ever experienced any trauma or anything that may have been threatening or harmful to him/her? (i.e. car accident, natural disaster, physical harm by another person, etc.)
   a. No b. Yes, explain:
4. Has your child ever witnessed or watched a harmful or threatening situation? (i.e. parental fighting, domestic violence, crime, etc.)
   a. No b. Yes, explain:

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