

Procentive Client # _____
(office use)

Child Intake Form *Counseling Services of Southern Minnesota*

Date of Referral: _____ **Service(s) Requested:** _____

Referred by: _____ **Phone or Email:** _____

Has your child received services at CSSM in the past? ☐ Yes ☐ No

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

Date of Birth: _____ **Sex:** _____

Parent Name: _____

Phone Number: _____ **Can we email or text you?** ☐ Yes ☐ No

Email: _____

Mailing Address: _____

Is legal custody shared with another parent? ☐ No ☐ Yes- same household ☐ Yes- separate households

If yes, joint parent name and phone number: _____

Site Preference: ☐ St. Peter ☐ Mankato ☐ Either

Primary Language: _____ **Do you need an interpreter?** ☐ Yes ☐ No

Insurance

Primary Insurance: _____

ID Number: _____ Group Number: _____

Subscriber Name, Birthdate: _____

Secondary Insurance: _____

ID Number: _____ Group Number: _____

Subscriber Name, Birthdate: _____

Billing Information/Contact (if different from above)

Name: _____ Phone: _____

Address: _____

Current Services:

Medical/Primary Care:	_____	Agency/Location:	_____
Therapist:	_____	Agency/Location:	_____
Case Manager:	_____	Agency/Location:	_____
Psychiatrist:	_____	Agency/Location:	_____

Please provide a brief reason for seeking services (current concerns):

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

Are you willing to work with a clinical intern (a graduate student under the supervision and guidance of a licensed therapist)?

☐ Yes ☐ No

Has or Does your child:

Seem excessively fearful or worried (e.g., refuse to leave caregiver, afraid of noises or dark)? ☐ Yes ☐ No

Have difficulty sleeping (e.g., nightmares, difficulty falling/staying asleep)? ☐ Yes ☐ No

Experienced trauma or a threatening event (e.g., car accident, physical harm by another)? ☐ Yes ☐ No

Witnessed a harmful or threatening situation (e.g., parental violence, crime)? ☐ Yes ☐ No

Attended inpatient or residential treatment within the last 6 months? ☐ Yes ☐ No

Engaged in self-harm in the past 30 days? ☐ Yes ☐ No

Received services from a mobile crisis program or law enforcement in the past 2 months? ☐ Yes ☐ No

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