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 <u>legal</u> 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