New Client Intake

Client Information

Client First Name: Middle: Last:

Gender: ☐ Female ☐ Male ☐ Trans ☐ Genderqueer/Non-Binary ☐ Other: ☐ Prefer not to Disclose

Race/Ethnicity: ☐ African-American ☐ Asian/Asian-American ☐ Native-American ☐ Latinx ☐ East-African ☐ West-African ☐ Caucasian ☐ Multiracial/Other: ☐ Prefer not to say

Date of Birth: Social Security # Phone #

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening Is it safe to leave a message? ☐ Yes ☐ No

Email: Preferred method of communication: ☐ Calls ☐ Texts ☐ Emails

Current Address:

Address Type: ☐ Client's ☐ Parent/Guardian ☐ Foster home ☐ Shelter ☐ Group home ☐ Other:

Who has custody of the client? ☐ Parents ☐ County ☐ Other:

Name of Parent(s)/Legal Guardian: Phone:

Foster Parent(s) (if applicable) Phone:

If Client is a minor, Who should the provider schedule with?

Primary Insurance: ☐ UCare ☐ Medica ☐ Medical Assistance ☐ HealthPartners ☐ BlueCross ☐ Cigna ☐ Other: _____ Is this policy: ☐ Medicaid ☐ Commercial

Commercial Plan ID # Group #

Medicaid Plan PMI #: Group #

Diagnostic and Medical Information/History

Primary Care Clinic:			
Street Address:		**City/State /Zip**	
Primary Care Physician Name:			
Phone Number:		**Fax Number :**	

Service Preferences:

Do you have a preference for a specific therapist? ☐ No ☐ Yes If yes, whom?

Any cultural or gender preference? ☐ No ☐ Yes If yes, please describe:

Is an interpreter needed? ☐ No ☐ Yes If yes, please describe:

Any other cultural/language considerations? ☐ No ☐ Yes If yes, please describe:

Client availability for services:

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

☐ Mornings ☐ Afternoons ☐ Evenings Scheduling Notes: