Adult General Intake Form

Adult(Client) Information:

First Name ______________________ **MI**__________ **Last Name** __________________________ **Birthdate** ___________

Cell Phone _________________________ **OK to leave message?** ☐ Yes ☐ No **OK to text?** ☐ Yes ☐ No

Home Phone _________________________ **OK to leave message?** ☐ Yes ☐ No **OK to text?** ☐ Yes ☐ No

Work Phone _________________________ **OK to leave message?** ☐ Yes ☐ No **OK to text?** ☐ Yes ☐ No

Email ____

Preferred Method of Contact: Cell Phone Home Phone Work Phone Email

Gender (circle one): Male Female Transgender Non-binary Prefer not to disclose

Preferred pronoun (optional): ____

Race (circle at least one): Black/African American White/Caucasian American Indian/Alaskan Native Asian Native Hawaiian/Pacific Islander Multiracial Prefer not to disclose

Are you of Hispanic/Latino origin? (circle one): ☐ Yes ☐ No

Primary reason for seeking services: ____

Please list any special health concerns or accommodations we should be aware of? _____________________________

Do you have current medical insurance? ☐ **Yes (*if yes, please complete the back of this form)***

☐ **No (*if no, please see office staff for alternate options)***

Emergency Contact Name ____ Relationship ____________________________

Emergency Contact's Cell Phone Number ____

The information in this box is for statistical purposes only and helps us continue providing low cost services as funders/grants require this data from nonprofits. Your participation is appreciated.

Number in household ________________
Does your family qualify for free/reduced lunches? Yes No
Does your family receive government assistance (social security, food stamps, disability, etc) Yes No
Total yearly household income (please write approximate amount or circle a range below) _______________
Under $10,000 | $10,000-$20,000 | $20,000-$30,000 | $30,000-$40,000 | $40,000-$50,000
$50,000-$60,000 | $60,000-$70,000 | $70,000-$80,000 | $80,000-$90,000 | Over $90,000

I hereby give consent to be treated at Lakes Center for Youth and Families. I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

___________________________________ ___________________________

Client Signature **Date**

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PRIMARY MEDICAL INSURANCE INFORMATION:

Primary Medical Insurance Provider: ____

MN Health Care Programs Identification Number (PMI) (if applicable): ____

Policy Holder Name: ______________________________________ Policy Holder's Date of Birth: _______________

Policy Holder's Address: ____

Policy Holder's City, State, and Zip Code: ____

Identification Number: _________________________________ Group Number: ___________________________

SECONDARY MEDICAL INSURANCE INFORMATION (if applicable):

Secondary Medical Insurance Provider: ____

MN Health Care Programs Identification Number (PMI) (if applicable): _____________________________________

Policy Holder Name: ______________________________________ Policy Holder's Date of Birth: _______________

Policy Holder's Address: ____

Policy Holder's City, State, and Zip Code: ____

Identification Number: _________________________________ Group Number: ___________________________