

# Youth General Intake Form



## Youth (Client) Information:

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of school building \_\_\_\_\_ Grade (or last completed) \_\_\_\_\_

CLIENT Cell Phone \_\_\_\_\_ OK to leave message?  Yes  No OK to text?  Yes  No

CLIENT Email: \_\_\_\_\_

Preferred Method of Contact: Client: Cell Phone Email Parent: Cell 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?:  Yes  No

Primary reason for seeking services: \_\_\_\_\_

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

Does the client have current medical insurance?  Yes *(if yes, please complete the back of this form)*

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

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Parent/Guardian Name: \_\_\_\_\_ Home: (\_\_\_\_) \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Street Address: \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ Township: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Home: (\_\_\_\_) \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Street Address: \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ Township: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

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I hereby give consent for the client listed above 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.

\_\_\_\_\_  
Parent or Legal Guardian 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: \_\_\_\_\_

**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