Log #: _____

C&S Clinic Intake & Registration Form – Adult

Directions: Please answer the following questions to the best of your knowledge.

Your records are confidential. Your information will not be released to any party without your written consent.

PATIENT INFORMATION

Last Name	First Name	Middle	Social Security Number	Date Form Completed

Street Address	City	State	Zip	OK to Send Letter? ☐ Yes ☐ No	Current Age

Home Phone	OK to Call? ☐ Yes ☐ No	Work Phone	OK to Call? ☐ Yes ☐ No	If No, How can you be reached?

Birth Date (MM/DD/YYYY)

Marital Status: ☐ Single (without partner) ☐ Separated ☐ Divorced ☐ Widowed ☐ Married ☐Single with partner (Length of Time in Relationship: _____)

Your Gender (*or preferred term*) ☐ Male ☐ Female ☐ Transgender ☐ _____

Your Sexual Orientation (*or preferred term*) ☐ Gay ☐ Straight ☐ Bisexual ☐ _____

Your Preferred Pronouns

Who Referred You?	Do You Have Children? ☐ Yes ☐ No	Number of children living with you:	Number of adults living with you:

CHECK ALL THAT APPLY:

Race / Ethnic Heritage:

☐ American Indian / Alaska Native
Enrolled? ☐ Yes ☐ No
Tribe: _____

☐ Asian American or Asian: _____
☐ Black/African American or African: _____
☐ White/European American: _____
☐ Native Hawaiian or other Pacific Islander: _____
☐ Hispanic, Chicano/a, or Latino/a: _____
☐ Other: _____

Employer (or School, if a student)	Position	Grade/Year, if a student	Highest Education: □ Elem. □ Jr. High □ High School □ Vocational □ Some College □ College Grad □ Grad School

Street Address	City	State	Zip	Phone

Emergency Contact Person & Relationship	Phone Number	Are you currently homeless? Yes or No	Are you currently living in public housing? Yes or No

GUARANTOR INFORMATION – *WHOEVER HOLDS THE INSURANCE POLICY OR MAKES PAYMENT; WRITE "SELF" IN 1ST BOX IF PATIENT IS GUARANTOR*

Last Name	First Name	Middle	Social Security Number	Relationship to Patient

Street Address	City	State	Zip	Home Phone	Work Phone

If you do not have insurance:

The Indian Health Board provides *free Eligibility Assistance* to help you apply. We will gladly schedule you to see our Insurance Navigator to find all your options.

Indian Health Board also has a sliding fee discount program based on income and ability to pay that may reduce the bill you owe. Please ask the registration staff for a Sliding Fee Discount Form.

INSURANCE INFORMATION - PRIMARY

□ Blue Cross/Shield/Plus	□ General Assistance (no HMO assigned)	□ HealthPartners	□ Medica	□ Medical Assistance (no HMO assigned)
□ Medicare	□ Metropolitan Health Plan	□ Minnesota Care	□ PreferredOne	□ UCare
□ Other: _____		□ Self-Pay / Sliding Fee	□ I would like to apply for insurance	

PMI # (Eight Digits):	Insured Member's ID #:	Policy / Group #:	Co-Pay Amount (if any):	Customer Service Phone #:

INSURANCE INFORMATION – SECONDARY (IF APPLICABLE)

□ Insurance Company	Insured Member's ID #:	Policy / Group #:	Customer Service Phone #:

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REFERRAL INFORMATION: *(REASON FOR WANTING SERVICES)*

Check all that apply:

☐ Depression	☐ Stress	☐ Grief / Death / Loss	☐ Alcohol Dependency	☐ Family of Origin Issues	☐ Eating Disorder
☐ Bipolar Depression	☐ Trauma	☐ Sexual Abuse/Trauma	☐ Drug Dependency	☐ Relationship Difficulties	☐ Phobia
☐ Inattention	☐ Anxiety	☐ Physical Abuse	☐ Fetal Alcohol Syndrome	☐ Legal Problems	☐ Schizophrenia
☐ Hyperactivity	☐ Panic Attacks	☐ Childhood Issues	☐ Learning Problems	☐ Parenting Concerns	☐ Psychiatric Hospitalization
☐ Mood Swings	☐ PTSD	☐ Past Foster Care	☐ HIV/AIDS/HEP-C	☐ Children Removed	☐ Methamphetamine Use
☐ Anger	☐ Domestic Abuse	☐ Historical Trauma	☐ Sexuality Concerns	☐ Help Finding Resources	☐ Prescription Drug Abuse

☐ Other *(Describe)*: _____

TYPE OF SERVICE(S) REQUESTED: *(CHECK ALL THAT MAY APPLY – A THERAPIST WILL DISCUSS OPTIONS WITH YOU)*

Check all that apply:

☐ Individual Therapy	☐ Family Therapy	☐ Parenting Support / Coaching	☐ Rule 25 Assessment
☐ Cultural Healing Activities	☐ Historical Trauma Group	☐ Drum Group	☐ Chemical Health Group
☐ Psychiatric Services	☐ Social Work / Resource Referrals	☐ Psychological Testing	☐ Other_____

YOUR **PRIMARY CARE PHYSICIAN**(S) AND PHYSICIAN SPECIALISTS

Name	Name	Name
Address	Address	Address
Phone:	Phone:	Phone:

OTHER CURRENT PROVIDER(S) OR PROFESSIONAL(S) – E.G., PSYCHIATRIST, SOCIAL WORKER, ADVOCATE, ETC.

Name	Name	Name
Address	Address	Address
Phone:	Phone:	Phone:

PAST PROVIDER(S) OR PROFESSIONAL(S) – E.G., PSYCHOLOGIST, PSYCHIATRIST, SOCIAL WORKER, ETC.

Name	Name	Name
Address	Address	Address
Phone:	Phone:	Phone:

FAMILY MEDICAL HISTORY: *(PLEASE √ IF YOUR FAMILY HAS A HISTORY OF:)*

Father and Father's Side of Family: ☐ *Check here if your father's medical history is unknown*

☐ Diabetes	☐ High Blood Pressure	☐ Alzheimer's	☐ Blood Clots / Stroke	☐ Cancer	☐ Heart Attack / Disease
☐ HIV/AIDS	☐ Hepatitis C	☐ Other Infectious Disease	☐ Epilepsy/Seizure	☐ Eating Disorder	☐ Autism
☐ Panic Attacks	☐ Depression	☐ Manic / Bipolar	☐ Suicide Attempt	☐ Schizophrenia	☐ Psychiatric Hospitalization
☐ Hyperactivity	☐ Inattention	☐ Enuresis	☐ Learning Problems	☐ Legal Problems	☐ Being in Foster Care
☐ Mental Retardation	☐ Physical Abuse	☐ Sexual Abuse	☐ Domestic Abuse	☐ Alcohol / Drug Abuse	☐ Fetal Alcohol Syndrome

Mother and Mother's Side of Family: ☐ *Check here if mother's medical history is unknown*

☐ Diabetes	☐ High Blood Pressure	☐ Alzheimer's	☐ Blood Clots / Stroke	☐ Cancer	☐ Heart Attack / Disease
☐ HIV/AIDS	☐ Hepatitis C	☐ Other Infectious Disease	☐ Epilepsy/Seizure	☐ Eating Disorder	☐ Autism
☐ Panic Attacks	☐ Depression	☐ Manic / Bipolar	☐ Suicide Attempt	☐ Schizophrenia	☐ Psychiatric Hospitalization
☐ Hyperactivity	☐ Inattention	☐ Enuresis	☐ Learning Problems	☐ Legal Problems	☐ Being in Foster Care
☐ Mental Retardation	☐ Physical Abuse	☐ Sexual Abuse	☐ Domestic Abuse	☐ Alcohol / Drug Abuse	☐ Fetal Alcohol Syndrome

Any other major conditions or information? _____

_____

YOUR MEDICAL HISTORY: *(Please √ if you have a history)*

☐ Diabetes	☐ High Blood Pressure	☐ Alzheimer's	☐ Mental Retardation	☐ Weight Problems	☐ HIV/AIDS
☐ Heart Attack/Disease	☐ Cancer	☐ Suicide Attempt	☐ Alcohol/Drug Abuse	☐ Epilepsy/Seizure	☐ Hepatitis C
☐ Blood Clots / Stroke	☐ Chronic Pain	☐ Problems with eyes	☐ Prescription Drug Abuse	☐ Rheumatoid Arthritis	☐ Tuberculosis (TB)
☐ Asthma	☐ Migraines/Headaches	☐ Sleep Problems	☐ Fetal Alcohol Syndrome	☐ Sexually Transmitted Infections (STI/STD)	

Any other major conditions or information? _____

_____

(Please Note – There is one more page remaining…) _____

YOUR MEDICATIONS: *(List more on separate page if necessary)*

Current Medications	For what condition?	Dosage	Frequency	Date started	Comments / Problems / Concerns

PAST MEDICATIONS / FOR WHAT CONDITION? (LIST SEDATIVES, PAIN MEDICATIONS, SLEEPING PILLS, ANTIDEPRESSANTS, ETC.)

Are you currently being treated for medical conditions? ☐ Yes ☐ No If yes, please list: _____

_____

YOUR NUTRITIONAL HEALTH: (PLEASE IDENTIFY THE STATE OF YOUR NUTRITIONAL HEALTH [E.G., DIET, HEALTHY EATING, ACCESS TO FOOD, ETC.])

☐ Poor ☐ Fair ☐ Good ☐ Vegetarian ☐ Gluten-sensitive ☐ Other: _____

YOUR ALLERGIES:

Medication Allergies? ☐ No ☐ Yes
If yes, what medication(s) _____

Substance or Food Allergies? ☐ No ☐ Yes
If yes, what substance(s) _____

PAIN ISSUES:

Chronic Pain? ☐ No ☐ Yes **If yes**, how much pain? ☐ Low ☐ Med ☐ High **If yes**, where are you treated? _____

YOUR LEARNING STYLE:

I prefer *(check all that apply):*			**Please circle your answer to the following:**		
	Talking, Asking Questions		I can read English well	Yes	No
	Reading		I can write English well	Yes	No
	Listening		I can hear well	Yes	No
	Pictures, Diagrams		I can see well	Yes	No
	Self-Study		I have no learning problems	True	No, I have learning disabilities

YOUR SOCIAL HISTORY

☐ Yes ☐ No	Do you use caffeine? If yes, how much, how often?
☐ Yes ☐ No	Do you smoke (including e-cigarettes) or use chewing tobacco? If yes, how many/much per day?
☐ Yes ☐ No	Do you use alcohol? If yes, how often, how much?
☐ Yes ☐ No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
☐ Yes ☐ No	Have you ever had or would you like help now with an alcohol or drug problem?
☐ Yes ☐ No	Would you like to discuss problems related to a sexual assault or sexual abuse?
☐ Yes ☐ No	Would you like to discuss problems related to physical abuse?
☐ Yes ☐ No	Would you like to discuss problems related to emotional abuse?
☐ Yes ☐ No	Would you like to discuss problems related to childhood neglect?
☐ Yes ☐ No	Are you now or have you ever been in a relationship where you have been physically hurt or threatened?

YOUR CULTURAL / SPIRITUAL HISTORY

☐ Yes ☐ No	Are there cultural or spiritual issues that you would like to discuss that would be important in counseling?

OTHER INFORMATION – HOW URGENTLY WOULD YOU LIKE TO BE SEEN?

☐	I would like to be seen as soon as possible.
☐	My concerns are important, but I am able to wait.
☐	I am willing to wait additional time because I want to see a specific therapist or type of therapist. Specify:

I certify that I have answered these questions to the best of my knowledge:

Patient Signature: _____ Date: _____

CLINICIAN'S NOTES

	Reviewed by (Clinician): Date: