Blue Earth County Mental Health Center

Demographic Intake

Legal Name: ______________________ **Preferred Name:** ______________________

Primary Phone: ______________________ ☐ Home ☐ Work ☐ Cellphone

Alternate Phone: ______________________ ☐ Home ☐ Work ☐ Cellphone

Primary Email Address: ______________________

Physical Address: ______________________

Mailing Address (if different from above): ______________________

County of Residence: ______________ **County of Financial Responsibility:** ______________

Birth Date: ____________ **Social Security Number:** ____________ **Gender:** ☐ Male ☐ Female

Race: ☐ White ☐ American Indian/Alaska Native ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Declined to answer

Marital Status: ☐ Single/Never married ☐ Married/Living with spouse ☐ Married/Involuntarily separated ☐ Divorced ☐ Married/Legally separated ☐ Married/Separated without legal ☐ Widowed ☐ Unknown

Highest Level of Education Completed: ☐ Some high school ☐ High school diploma ☐ GED ☐ Some college ☐ 2-year college ☐ 4-year college ☐ Masters/higher

Tobacco User: ☐ Non-user ☐ User ☐ Unable to collect

Type of User: ☐ Cigarette smoker ☐ Vapor smoker ☐ Other smoker ☐ Chew tobacco

Smoking Status: ☐ Current every day smoker ☐ Current someday smoker ☐ Current smoker status unknown ☐ Former smoker ☐ Never smoked ☐ Unknown if ever smoked ☐ Heavy tobacco smoker ☐ Light tobacco smoker

Primary Language: ☐ English ☐ Spanish ☐ Arabic ☐ French ☐ German ☐ Sudanese ☐ Vietnamese ☐ Declined ☐ Sign language

Interpreter Needed: ☐ Yes ☐ No If yes, type of interpreter needed: ______________________

Legal Guardian: ☐ Yes ☐ No

If yes, name/address/phone number: ______________________

Minor Parent(s) Name(s): ______________________

Address/phone number the same as above: ☐ Yes ☐ No

If no, address/phone number: ______________________

Emergency Contact Name and Phone Number: ______________________

Clinical Intake

Referral Source: ______________________________

Services Requested: ☐ Therapy ☐ Psychiatry ☐ Urgent Care ☐ Consultation ☐ Second Opinion

Primary Concerns: ______________________________

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Mental Health Diagnosis: ______________________________

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Serious and Persistent Mental Illness (SPMI): ☐ Yes ☐ No

Previous Diagnostic Assessment: ☐ Yes ☐ No If yes, date: ______________

Current Services:

Primary Care Provider: ______________ Location: ______________

Therapist: ______________ Location: ______________

Case Manager: ______________ Location: ______________

Other: ______________ Location: ______________

Other: ______________ Location: ______________

Current Medications	Prescriber

Medical Concerns/Diagnosis: ______________________________

List Any Hospitalizations or CD Treatment in Past 10 Years: ______________________________

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To Prevent Conflict of Interest, List Any Family Members Seen at Blue Earth County Mental Health Center:

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Financial Intake

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Self-employed ☐ Unemployed ☐ Unknown

If Employed - Employer: ______________________________

Address: ______________________________

Employer: ______________________________

Address: ______________________________

Household Information:

Adjusted Gross Household Income: ______________

Number of Family Members: ________

Insurance:

Primary Insurance: ______________________________

Group Number: ______________________ ID Number: ______________________

Subscriber's Name: ______________________ Relationship to Patient: ______________________

Secondary Insurance: ______________________________

Group Number: ______________________ ID Number: ______________________

Subscriber's Name: ______________________ Relationship to Patient: ______________________

Send in copy of card for all primary and secondary insurances. Insurance cards are needed within 30 days.

Billing Information/Contact - Send Statement To (if different than above):

Name: ______________________________

Address: ______________________________

Phone Number: ______________________ Relationship to Patient: ______________________

If you want to see if you qualify for a reduced fee, please submit all verifying information of income. This would include last 30 days of paystubs or the past year's tax information for all household members. This information is required within 30 days of completing this form or prior to your first appointment. IF this information is not provided, you may be charged full fee.

SE/
8-27-15
Intake Sheet.Doc