



CLIENT INTAKE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HUMAN SERVICE CENTERS
SFN1843 (5-2024)

Are you having violent or suicidal thoughts or feelings?

If **"YES"**, please return to the front desk staff and let them know.
If **"NO"**, please fill out the below information.

The information requested on this form will be kept confidential. Fill out the form as completely as possible.

**In compliance with the Federal Privacy Act of 1974, disclose of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.*

CLIENT DEMOGRAPHICS

Legal Name (First, Middle Initial, Last)				
Preferred Name(s)		Social Security Number *		Date of Birth
Mailing Address		City		State ZIP Code
Physical Address		City		State ZIP Code
Email Address		Home Phone Number		Cell Phone Number
Primary Language		Highest Level of Education		Religion
Living Arrangement <input type="checkbox"/> Rent/Own <input type="checkbox"/> Assisted Living/Nursing Facility <input type="checkbox"/> Jail <input type="checkbox"/> Homeless <input type="checkbox"/> Other (specify): _____				
Marital Status <input type="checkbox"/> Single/Never Married <input type="checkbox"/> Married/Domestic Partner <input type="checkbox"/> Divorced/Annulled <input type="checkbox"/> Widowed				
Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Other (specify): _____				
Occupation				Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer				
Race <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Other Single Race <input type="checkbox"/> Two or More Races <input type="checkbox"/> Unknown <input type="checkbox"/> White/Caucasian	Ethnic Origin <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black Non-Hispanic <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American, Aleutian, Eskimo <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> White Non-Hispanic	Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female Preferred Pronouns <input type="checkbox"/> He/Him/His <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> They/Them/Theirs	Gender Identity <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Gender Queer <input type="checkbox"/> Transgender (MTF) <input type="checkbox"/> Transgender (FTM) <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Choose not to disclose	Sexual Orientation <input type="checkbox"/> Bisexual <input type="checkbox"/> Homosexual (Lesbian/Gay) <input type="checkbox"/> Heterosexual (Straight) <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Choose not to disclose
Are you having suicidal thoughts, such as wishing you were dead? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you having thoughts about hurting others? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you been hospitalized in the last 30 days for mental health or addiction treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you receiving mental health or substance use treatment at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No				
In the last year have you used IV drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, what is your expected due date: _____				

INSURANCE INFORMATION

****Please give the Front Desk Staff any Insurance Cards you have along with this form****

Do you have medical insurance?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes - What insurance do you have?
<input type="checkbox"/> Blue Cross Blue Shield (BCBS)	<input type="checkbox"/> ND Medicaid (Medical Assistance)
<input type="checkbox"/> BCBS Medicaid Expansion	<input type="checkbox"/> Sanford Health Plan
<input type="checkbox"/> Medicare	<input type="checkbox"/> Tricare
<input type="checkbox"/> Medicare Replacement	<input type="checkbox"/> Other (specify): _____

Primary Insurance Company

Primary Insurance Company	
Primary Group Number	Primary ID Number
Primary Subscriber	
Primary Subscriber Date of Birth	

Secondary Insurance Company

Secondary Insurance Company	
Secondary Group Number	Secondary ID Number
Secondary Subscriber	
Secondary Subscriber Date of Birth	

If NO Insurance , do you need assistance with getting coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
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PARENT/LEGAL REPRESENTATIVE (if client is a minor or has a guardian)

*If you are signing this form as a legal representative other than a parent of a minor child, you must attach documentation that establishes your legal authority to act on behalf of the client if not already on file with the Department.

Name		Telephone Number	
Address	City	State	ZIP Code
Relationship	Does this parent/legal representative reside with the client? <input type="checkbox"/> Yes <input type="checkbox"/> No		

EMERGENCY CONTACT Same as the parent/legal representative

If Emergency Contact is different than parent/legal representative, complete below:

Name		Telephone Number	
Address	City	State	ZIP Code
Relationship	Does this parent/legal representative reside with the client? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Return this completed paperwork to the front desk or other clinical staff.