CLIENT INTAKE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HUMAN SERVICE CENTERS
SFN1843 (2-2025)

Clear Fields

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)		Date	
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
☐ Rent/Own ☐ Assisted Living/Nursing Facility ☐ Jail ☐ Homeless ☐ Other (specify): _____

Marital Status
☐ Single/Never Married ☐ Married/Domestic Partner ☐ Divorced/Annulled ☐ Widowed

Employment Status
☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Other (specify): _____

Occupation	Are you a Veteran? ☐ Yes ☐ No
Employer	

Race
☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Pacific Islander ☐ Black/African American ☐ Other Single Race
☐ Two or More Races ☐ Unknown ☐ White/Caucasian

Ethnic Origin
☐ Asian/Pacific Islander ☐ Black Non-Hispanic ☐ Hispanic/Latino ☐ Native American, Aleutian, Eskimo ☐ White Non-Hispanic
☐ Other (specify): _____

Sex Assigned at Birth
☐ Declined to Answer ☐ Male ☐ Female ☐ Unknown ☐ Intersex ☐ X

Preferred Pronouns
☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs

Gender Identity
☐ Female ☐ Male ☐ Gender Queer ☐ Transgender (MTF) ☐ Transgender (FTM) ☐ Choose not to disclose
☐ Other (specify): _____

Sexual Orientation
☐ Bisexual ☐ Homosexual (Lesbian/Gay) ☐ Heterosexual (Straight) ☐ Choose not to disclose
☐ Other (specify): _____

Are you having suicidal thoughts, such as wishing you were dead? ☐ Yes ☐ No
Are you having thoughts about hurting others? ☐ Yes ☐ No

Have you been hospitalized in the last 30 days for mental health or addiction treatment? ☐ Yes ☐ No
Are you receiving mental health or substance use treatment at this time? ☐ Yes ☐ No
In the last year have you used IV drugs? ☐ Yes ☐ No
Are you currently pregnant? ☐ Yes ☐ 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?

☐ No ☐ Yes - What insurance do you have?

- ☐ Blue Cross Blue Shield (BCBS)
- ☐ BCBS Medicaid Expansion
- ☐ Medicare
- ☐ Medicare Replacement
- ☐ ND Medicaid (Medical Assistance)
- ☐ Sanford Health Plan
- ☐ Tricare
- ☐ 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?
☐ Yes ☐ No

PARENT/LEGAL REPRESENTATIVE (*if client is a minor or has a guardian*)

*If you are filling out 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? ☐ Yes ☐ 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? ☐ Yes ☐ No		

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