



Hoffmann Counseling Services

510 Sibley Street
Mankato, MN 56001

Phone: (507)484-2400 Fax: (507)304-7149

Intake

Referral Source:			
Name/Title:		Date:	
Agency:		Phone:	
Address:			
Email:		Fax:	

Eligible Participant:			
Legal Name:		Date of Birth:	
Preferred Name:		Gender Assigned	Female
		At Birth:	Male
Address:		Pronouns:	
Phone:			
Email:			
Emergency Contact:		Relationship:	Phone Number:

Ethnicity:			
<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> African American	<input type="checkbox"/> Asian
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	
<input type="checkbox"/> American Indian/Alaskan Native Tribe:	<input type="checkbox"/> Other:		
Primary Language:		Interpreter Services:	

Guardian 1	<input type="checkbox"/> NA	Guardian 2	<input type="checkbox"/> NA
Name:		Name:	
Address:		Address:	
Email: Client portal access		Email: Client portal access	
Phone:		Phone:	
Other significant person:			

Household Members:		
Name	Age/DOB	Living in the home?

Allergies:	
Medical Considerations:	
DSM-5 Diagnosis (if applies):	

Case Manager:		Phone:
Probation:		Phone:
Therapist:		Phone:
Psychiatrist:		Phone: Location:

Insurance:			
Insurance Company Name:			
Insurance Company Phone:			
Subscriber ID Number:	Group Number:		
Payer ID:			
Subscriber Name:	Subscriber DOB:		
Subscriber Address:			
Subscriber Relationship:			
County Pay:	<input type="checkbox"/>	Yes	County:
	<input type="checkbox"/>	No	
Medical Assistance:	<input type="checkbox"/>	Yes	MA Number:
	<input type="checkbox"/>	No	

Previous Providers, Assessments, School Reports, or Evaluations

Contact Name	Clinic & Address	Phone

Reason for Referral (fill in text box):

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Service Requested (check all that apply):

<input type="checkbox"/>	Diagnostic Assessment	<input type="checkbox"/>	Trauma Focused Services
<input type="checkbox"/>	Individual Therapy	<input type="checkbox"/>	Family Therapy
<input type="checkbox"/>	Parenting	<input type="checkbox"/>	CTSS (Skills Training/Rehabilitative Services)
<input type="checkbox"/>	Play Therapy	<input type="checkbox"/>	ARMHS (Adult Rehabilitative Mental Health Services)
<input type="checkbox"/>	Birth to Five Assessment/Therapy	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Teletherapy (please add email address)		

Please attach the following documents as available:

<input type="checkbox"/>	Recent Social History	<input type="checkbox"/>	Recent Psychological Assessment
<input type="checkbox"/>	Police Reports	<input type="checkbox"/>	Copy of Court Orders
<input type="checkbox"/>	School Records (IEP)	<input type="checkbox"/>	Any Other Relevant Information
<input type="checkbox"/>	Current Diagnostic Assessment	<input type="checkbox"/>	Releases of Information
<input type="checkbox"/>	Current Insurance Card (Front & Back)		

How did you hear about Hoffmann Counseling Services?

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***Please Fax completed form to (507) 304-7149**