Acct #: ____________________ Referred by: ______________________________

Appt Date ______________ Therapist: ___________________ Diagnosis: ___________________

NORTHSHORE CLINIC, LLC
805 NORTH 6TH STREET SHEBOYGAN, WI 53081
920-457-8866

MINOR INTAKE FORM/INSURANCE INFORMATION

Name of Client: ____
(Last, First, Middle Initial) Birthdate Sex Age

Address: ____
Street City State Zip Code

Mother's Name: ______________________________ **Birthdate:** ______________
Address: ____

Father's Name: ______________________________ **Birthdate:** ______________
Address: ____

	Mother	**Father**
May we call you at home?	**Y N** _______ (initial) Phone#: ____________________	**Y N** _______ (initial) Phone#: ____________________
May we call you on your cell phone?	**Y N** _______ (initial) Phone#: ____________________	**Y N** _______ (initial) Phone#: ____________________
May we call you at work?	**Y N** _______ (initial) Phone#: ____________________	**Y N** _______ (initial) Phone#: ____________________
Message restrictions?	**Y N** _______ (initial) ____________________________	**Y N** _______ (initial) ____________________________
May we correspond by email?	**Y N** _______ (initial) Email: ____________________	**Y N** _______ (initial) Email: ____________________

CONSENT FOR TREATMENT OF MINOR CHILD

As the Legal Custodian/Guardian for ________________________, I give permission to Northshore Clinic, LLC
(Name of Child)
to treat my child and **UNDERSTAND I WILL BE FINANCIALLY RESPONSIBLE FOR THE ENTIRE COST OF THE TREATMENT.** This treatment may include individual counseling, family counseling, or group psychotherapy, as well as psychological testing or AODA assessment and treatment. This treatment may include consultations with associates of this Clinic.

____
Signature of Legal Custodian/Guardian Date

PLEASE TURN THIS PAGE OVER FOR INSURANCE INFORMATION

PRIMARY INSURANCE

Subscriber Name (Last, First, Middle) Birthdate Sex

Subscriber Address City State Zip Code

Home Phone Work Phone Employer

Insurance Company Name Phone Number

Address City State Zip Code

Identification Number Group Number

Relationship to Patient: ___________

SECONDARY INSURANCE

Subscriber Name (Last, First, Middle) Birthdate Sex

Subscriber Address City State Zip Code

Home Phone Work Phone Employer

Insurance Company Name Phone Number

Address City State Zip Code

Identification Number Group Number

Relationship to Patient: ___________

It is your responsibility to inform our office if your insurance changes or you acquire any type of Medicaid coverage at a later time. If you do not provide us with the updated/accurate information in a timely manner you may be responsible for the balance of your bill.

________________ (Please initial)

NORTHSHORE CLINIC, LLC
805 North 6th Street
Sheboygan WI 53081
(920) 457-8866

CONSENT TO USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION

Client Name ___________________ **Account Number** _______________

Date of Admission ______________

By signing this form, you are agreeing to let us use your personal health information (PHI) here and to send it to those outlined in our Notice of Privacy Practices. You are acknowledging that you have read Northshore Clinic's Notice of Privacy Practices (summarized or full version) and understand how your health information can be used or disclosed (shared), as described therein. You are agreeing that you have been offered a copy of our Notice of Privacy Practices (NPP) and have been encouraged to discuss any concerns you may have. You have also been given a copy of your rights as a patient of Northshore Clinic, LLC, including your right to restrict, review or stop this consent.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you. In addition, if you choose to revoke this consent at any time, treatment will terminate.

If in the future, we change our Notice of Privacy Practices, we will post and date any changes made and provide copies of our new NPP for your review.

_____________________________________ _____________
Signature of client or legal representative Date

____
Description of legal representative's authority

TO BE COMPLETED BY ADMITTING CLINICIAN

Was the client asked if they had any questions or concerns about Northshore's Notice of Privacy Practices?

☐ YES

______________________________________ ____________________

Signature of Staff Member Date

TO BE COMPLETED BY OFFICE STAFF

Briefly describe the efforts made to obtain the client's signature and explain why the client was unable or unwilling to sign this form:____

____

____

____

____

________________________________ ____________________

Signature of Staff Member Date

MEDICAL HISTORY

NAME: ___________________________ AGE: _____ DATE OF BIRTH: __________ DATE: __________

Have you ever had or been treated for the following conditions:

❒ Allergies	❒ Blood Disease	❒ Blood Pressure	❒ Back Trouble
❒ Hay Fever	❒ Cancer	❒ Heart Disease	❒ Arthritis
❒ Asthma	❒ Diabetes	❒ Kidney Disease	❒ Chronic Pain
❒ Emphysema	❒ Low Blood Sugar	❒ Bladder Problems	❒ Headaches
❒ Skin Problems	❒ Thyroid Problems	❒ Prostate Disease	❒ Injury/Fracture
❒ Constipation	❒ Liver Disease	❒ Menstrual Problem	❒ Epilepsy/Seizure
❒ Stomach Problems	❒ Hearing Problems	❒ Abortion/Miscarry	❒ Eating Disorder
❒ Irritable Bowel	❒ Vision Problems	❒ Sexual Problems	❒ Drinking Problem
❒ Weight Problems	❒ Dental Problems	❒ Sleep Problems	❒ Drug Abuse

Please list any hospitalizations (dates and reasons):____

____

Please list all prior mental health services received:

With Whom: Year: How Long: For What:

Have you ever been: physically abused ❒ or sexually molested ❒ ?

Are you currently under the care of a doctor for any physical or emotional condition?
If so, please list doctor's name, reason for treatment, date last seen: ______________________________________

____

Current medications you are taking: ____

____

Current Health Concerns: Please check any area where you think you may have a problem:

❒ Hearing/Vision	❒ Anxiety/Nervousness	❒ Interpersonal Relationships
❒ Speech	❒ Depression	❒ School Problems
❒ Dental Health	❒ Anger or Temper	❒ Work/Job/Career Problems
❒ Breathing	❒ Frequent Mood Changes	❒ Marital Problems
❒ Circulation	❒ Guilt	❒ Parenting Skills
❒ Digestion	❒ Self-Concept	❒ Sexuality
❒ Bowel Function	❒ Tiredness/Fatigue	❒ Problems with Relatives
❒ Urinary Function	❒ Sleep Disturbances	❒ Legal
❒ Joint/Muscle Function	❒ Suicide Ideas	❒ Exercise, Hobbies
❒ Skin Condition	❒ Indecision	❒ Drinking Problems
❒ Pain	❒ Memory/Concentration	❒ Drug Problems
❒ Menstrual Cycle	❒ Eating/Appetite	❒ Behavior Problems
❒ Menopause	❒ Weight Loss/Gain	❒ Other:________________
❒ Smoking	❒ Phobias	

Name of your physician: ____

Client Signature: ____ Date: ________________