Center for Life
COUNSELING

Intake Assessment

Today's Date:_____

Referral Source

How did you hear about our agency?_____

Counseling Program

☐Council Bluffs
☐Des Moines
☐Pregnancy Counseling
☐Ankeny
☐Perry
☐Waukee

Client Information

First Name | Middle Initial | Last Name

Address | City | State | Zip

Email | Home Phone ( ) | Cell Phone ( ) | Work Phone ( )

You may call my ☐Home ☐Cell ☐Work ☐I prefer not to be contacted by email
You may leave a message at ☐Home ☐Cell ☐Work

Date of Birth | Age | Social Security Number | Gender: ☐Male ☐Female

Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced ☐Common Law ☐Domestic Partner

Race: ☐White, Caucasian ☐Black, African American ☐Asian ☐American Indian/Native Alaskan ☐Hawaiian/Other Pacific Islander ☐Bi-racial ☐Multi-racial ☐Other ☐Choose not to respond

What is the primary language spoken at home? _____

What is your country of origin? _____

Hispanic: ☐Yes ☐No ☐Unknown

Employment/School Status

Employment Status: ☐Full-time ☐Part-time ☐Seasonal/Temporary ☐Unemployed ☐Retired ☐Disability ☐Self-employed

Name of Employer: _____ City: _____

Occupation: _____

School Status: ☐Full-time ☐Part-time ☐Alternative ☐Dropped out

Name of school currently attending: _____ City: _____

Highest level of educational attainment:
☐8th grade or less
☐9th-12th grade, no diploma
☐High school diploma, or equivalent
☐Technical or Trade school
☐Some college
☐2-year degree (AA, AS)
☐4-year degree (BA, BS)
☐Master's degree or Professional degree

Emergency Contact Information

Last Name | First Name | Relationship

Address | City | State | Zip

( ) Home Phone | ( ) Cell Phone | ( ) Work Phone

Insurance/Income

Are you currently covered by health insurance? ☐Yes ☐No

Total annual gross family income: $_____ Number of dependents living in your home: ___ Adults ___ Children

Catholic Charities Counseling Services
Health Assessment

Presenting Problem(s)

Primary (1st) _____ Secondary (2nd) _____ Tertiary (3rd) _____

01-medical/physical	06-family	11-housing/basic needs	16-self harm
02-emotional/psychological	07-abuse/neglect	12-financial	17-work related
03-substance abuse	08-work relationships	13-legal	18-grief/death stress
04-other addictions	09-peer/friendships	14-educational	19-other _____
05-maritial/relationship	10-employment	15-suicidal	

In the last month, how much of the time has your problem(s) interfered with your everyday activities?

☐All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐None at all

Medications

Are you currently taking any prescription or over the counter medications? ☐Yes ☐No

If yes, please list all medications you are currently taking:

Drug Name	Dose	Frequency	Reason	Prescribing Physician

Emergency Health Needs/Coordinating Care

Please list any emergency health needs: _____

Are you in impending danger at this time? ☐Yes ☐No If yes, please explain: _____

_____

How would you rate your current physical health information: ☐Good ☐Fair ☐Poor

Are you currently being treated by a medical doctor? ☐Yes ☐No

Are you now, or have you ever been under the care of a psychiatrist? ☐Yes ☐No

Have you ever been in counseling? ☐Yes ☐No If yes, when and where? _____

Are you currently coordinating your care with another individual? ☐Yes ☐No If yes, please indicate who:

☐Primary Care Physician ☐Psychiatrist ☐Parole Officer ☐Dept. of Human Services ☐Other _____

Catholic Charities Counseling Services
Functioning Assessment

Looking back over the last few weeks, including today, help us understand how you have been feeling. Read the statement below and circle the number that best represents how you feel.

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
I am dealing well with everyday problems.	1	2	3	4	5
I am coping when things go wrong.	1	2	3	4	5
I am satisfied with my performance at work/school.	1	2	3	4	5
I am satisfied with my child(ren)'s performance at school.	1	2	3	4	5
I am satisfied with my child(ren)'s behavior.	1	2	3	4	5
I get along with family members.	1	2	3	4	5
I get along with friends and other people.	1	2	3	4	5
I am able to stay focused and concentrate.	1	2	3	4	5
I am sleeping well.	1	2	3	4	5

Client Fee Agreement

Our staff is committed to providing you with professional service. Regular payment of your bill is considered an important part of your counseling process. In order for our work together to be productive, it is important that expectations be clearly defined.

What you can expect from us:

- Therapy sessions are 50 minutes long.
- The information you share with us will be kept confidential (Exceptions are explained below).
- To notify you as soon as possible if we have to cancel or reschedule your appointment.
- To make every effort to be on time for your appointments and to return your phone calls as soon as possible.
- To work with you to set achievable goals and to assist you in making progress toward these goals.

What we expect from you:

- To be actively involved in setting your therapy goals and working towards them.
- To attend scheduled appointments. **In the event that you need to cancel or reschedule your appointment, we require 24 hours notice.** Please contact our office during normal office hours or by calling and leaving a message after hours.
- **Failure to show up or cancel within 24 hours of a scheduled appointment will result in a $10.00 cancelation fee.** All fees must be paid before another appointment will be scheduled. After two consecutive no shows or cancellations for a scheduled appointment, we will no longer be able to provide further services.
- To take financial responsibility by keeping your account current. **Payment is expected at the time of service.** If you are unable to pay the fee, you must make arrangements to pay the balance in full at your next scheduled appointment. **If after two sessions your account is not current, a third appointment will not be scheduled until that account balance is paid in full.**

Payment and Fees

We accept payment from most major insurance carriers. Please check with your insurance company and work with our staff regarding your policy coverage for behavioral/mental health counseling. If you are covered by insurance, it is our policy to bill your insurance provider, or charge you the full hourly rate of $125 for the services you receive. You are financially responsible for any amount not covered by your insurance contract. Insurance deductibles and co-payments are due at the time of your appointment.

If you are not covered by insurance, Catholic Charities uses a sliding fee scale which is based on total annual gross family income and number of persons residing in the household. This fee will be determined at your first appointment and may be adjusted if circumstances change. Catholic Charities accepts payment in the form of cash, check, money order, or by credit/debit card. We do not accept flex spending cards.

Confidentiality

Your right to privacy and confidentiality is highly safeguarded at Catholic Charities. Only your written permission will allow us to share information about anything that has transpired during your contact with us. Staff notes are entirely confidential. **Exceptions are:**

- All counselors are mandatory reporters for child abuse and elderly/dependent adult abuse
- Clients who threaten to harm themselves or someone else and the therapist assess the case as "high risk"
- In certain situations, therapist may be required to respond to a subpoena
- Weekly clinical consultation with staff

I agree to pay $_____ per session (co-pay or sliding fee) for services provided by Catholic Charities.
Per my Insurance, I have a limit of _____visits per benefit period.

_____
Printed Name

_____ _____
Signature Date

If client is under 18 years of age:

_____
Parent/Legal Guardian's Printed Name

_____ ( ) _____
Address City State Zip Code Phone

_____ _____
Parent/Legal Guardian's Signature Date

_____ _____
Therapist's Signature Date

Catholic Charities Counseling Services
Handbook Acknowledgement

I have been informed of my rights and responsibilities. I acknowledge by signing this form that I have received a copy of Catholic Charities Client Handbook which includes:

- Mission Statement
- Program Locations and Hours of Operations
- Client Rights and Responsibilities
- Client and Catholic Charities Right to Refuse Services
- Discharge and Termination of Services
- Service to Minors without Parental Consent
- Complaints and Appeals
- Mandatory Child Abuse Reporting
- Behavior Support and Management Policy/Practice
- Duty to Warn
- Privacy Act Notice

_____
Printed Name

_____ _____
Signature Date

If client is under 18 years of age:

_____
Parent/Legal Guardian's Printed Name

_____ _____
Address City State Zip Code ( ) Phone

_____ _____
Parent/Legal Guardian's Signature Date

_____ _____
Therapist's Signature Date