Intake Assessment

Today's Date:_____

Referral Source: How did you hear about our agency?_____

Client Information

First Name | Middle Initial | Last Name

Address | City | State | Zip

Email | Primary Phone ( ) | Other Phone ( ) | Work Phone ( )

You may call/contact my ☐Primary ☐Other ☐Work ☐email
You may leave a message at ☐Primary ☐Other ☐Work

Date of Birth | Age | Gender

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

Hispanic: ☐Yes ☐No ☐Unknown

What is the primary language spoken at home? _____

What is your country of origin? _____

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

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

List all people currently living in your home:

Name	Age	Relationship to you

List all children, stepchildren, or children-in-law NOT living in your home:

Name	Age	Relationship to you

Employment/School Status

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

Name of Employer: _____ City: _____ Occupation: _____

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

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

Name of school currently attending: _____ City: _____

Emergency Contact Information

Last Name	First Name	Relationship
Address	City	State Zip
( ) Home Phone	( ) Cell Phone	( ) Work Phone

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

Please list all prescription and over-the-counter medications you are currently taking (use back of page if needed):

Drug Name	Dose	Frequency	Prescribing Physician	Reason
Drug Name	Dose	Frequency	Prescribing Physician	Reason
Drug Name	Dose	Frequency	Prescribing Physician	Reason

Emergency Health Needs/Coordinating Care

Do you have thoughts of hurting yourself or ending your life? ☐Yes ☐No

Are you afraid someone else might hurt you? ☐Yes ☐No

Do you have thoughts of hurting someone else? ☐Yes ☐No

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

Are you currently being treated by a medical doctor? ☐Yes ☐No If yes, who? _____

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

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

Have you had any inpatient treatment for mental health? ☐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 _____

Substance Use History

Do you currently drink alcohol? ☐Yes ☐No If yes, approximately how many drinks per week? _____

Do you currently or have you ever used illegal substances? ☐Yes ☐No If yes, what? _____

How often? _____ When (at what age, and for how long)? _____

Have you had any inpatient treatment for substance abuse? ☐Yes ☐No If yes, when and where? _____

Have you ever had a drug or alcohol evaluation? ☐Yes ☐No If yes, when and where? _____

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, or activities of daily living.	1	2	3	4	5
I am happy with my relationship with my spouse/significant other.	1	2	3	4	5
I am happy with my relationships with my family.	1	2	3	4	5
I am happy with my relationships with my friends.	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
I have gained or lost weight recently.	1	2	3	4	5
I feel lonely.	1	2	3	4	5
I feel hopeless about the future.	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.**

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

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.

☐ I agree to pay the amount not covered by my insurance company for services provided by Catholic Charities (for more information about insurance coverage, call your insurance provider).

OR

☐ I do not have health insurance and am using the sliding fee scale. I agree to pay $_____ per session for services provided by Catholic Charities, and understand that this amount could change if my income or number of dependents changes, or for regular changes in the Catholic Charities sliding fee scale.

_____
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 Credentials 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 Credentials Date

Insurance Information

Primary Insurance Carrier

Name of Primary Insurer (Company Name)

Address of Policy Holder | City | State | Zip

Policy Number | Group Number

Policyholder's Last Name | First Name | Middle Initial | Date of Birth

Policyholder's Employer | Social Security Number

Relationship to Policyholder: ☐Self ☐Spouse ☐Child ☐Other

Secondary Insurance Carrier

Name of Secondary Insurer (Company Name) | Office Co-Pay Amount

Address | City | State | Zip

Policy Number | Group Number

Policyholder's Last Name | First Name | Middle Initial | Date of Birth

Policyholder's Employer | Social Security Number

Relationship to Policyholder: ☐Self ☐Spouse ☐Child ☐Other

Authorization

I authorize Catholic Charities to release any Protected Health Information (PHI) necessary to process insurance claims for services received at Catholic Charities. Unless explicitly authorized by me, the Psychotherapy Notes will not be disclosed to my insurance carrier or managed care company. I further authorize payment of benefits to which I am entitled form any insurance company to Catholic Charities for services described on any insurance claim filed on my behalf. I understand I am financially responsible for any amount not covered by my insurance contract.

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