CATHOLIC CHARITIES
DIOCESE OF DES MOINES
Counseling Program

601 Grand, Des Moines, IA 50309
515-237-5045
catholiccharitiesdm.org

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

Have you ever been arrested for a crime? ☐Yes ☐No

Are you a refugee? ☐Yes ☐No

Are you a United States Veteran? ☐Yes ☐No

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

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Employment/School Status

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

Name of Employer: _____ 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

Presenting Problem

What are the problem(s) for which you are seeking help?

How often does this problem occur (daily, weekly, monthly, etc)?

How much does this problem bother you (a little, a moderate amount, a lot, etc)?

Current Symptoms

Review each symptom and if experiencing it, select the checkbox and for each marked item indicate how often the symptom occurs during in a week.

Symptom	Frequency			
	Slight	Mild/Several days	Moderate/More than half the days	Severe/Daily
	1	2	3	4

□ Panic Attacks
□ Appetite, Increased
□ Appetite, Decreased
□ Depressed Mood
□ Easily Distracted
□ Engage in Risky Behaviors
□ Excessive Energy
□ Excessive Worry
□ Fatigue

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□ Feeling Hopeless
□ Feelings of Abandonment
□ Feelings of Emptiness
□ Guilt
□ Impulsive
□ Unable to Feel Pleasure
□ Increased Activity
□ Increased Need for Sleep
□ Unable to Fall Sleep
□ Paranoia
□ Preoccupied with Sex
□ Racing Thoughts
□ Talkativeness
□ Worthlessness

Other Symptoms (specify) How often other symptoms occur during the day?

When did the symptom(s) start?

How much do these symptoms bother you (a little, a moderate amount, a lot, etc)?

Are these symptoms affecting any of the following?
Circle or check if symptoms are affecting any area of your life.

□ Activities of Daily Living
□ Finances
□ Housing
□ Legal Matters
□ Recreational Activities
□ Relationships
□ School
□ Self-Esteem
□ Sexual Activity
□ Work

How much do these symptoms affect your life (a little, a moderate amount, a lot, etc)?

Medical History
Do you need us to contact your Primary Provider?

Name of Primary Provider and Contact Information

Do you have any concerns about your physical health that you would like to discuss?

Select the checkbox if you have been diagnosed with any of the following problems.
□ Anemia
□ Diabetes
□ Arthritis
□ Head Trauma
□ Asthma
□ Seizures
□ Chronic Fatigue
□ Chronic Pain
Other Problems (specify)
_____

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Past Psychiatric History
Have you ever had Outpatient Treatment?
Yes/No

If yes, list the reason and dates treated.

Have you ever had Inpatient Psychiatric Hospitalization?
Yes/No

If yes, list the reason and dates treated.

Family Psychiatric History
Select the family member who has been diagnosed or treated for any of the following diagnosis.

Alcohol Abuse	□ Child	□ Parent	□ Sibling	□ Grandparent
Anger	□ Child	□ Parent	□ Sibling	□ Grandparent
Anxiety	□ Child	□ Parent	□ Sibling	□ Grandparent
Bipolar Disorder	□ Child	□ Parent	□ Sibling	□ Grandparent
Depression	□ Child	□ Parent	□ Sibling	□ Grandparent
Post-traumatic Stress	□ Child	□ Parent	□ Sibling	□ Grandparent
Schizophrenia	□ Child	□ Parent	□ Sibling	□ Grandparent
Substance Abuse	□ Child	□ Parent	□ Sibling	□ Grandparent

Past/Current Psychiatric Medications
Please list all prescription and over-the-counter medications you are currently taking or have taken before (use back of page if needed):

Drug Name	Dose	Frequency	Prescribing Physician	Reason	Date stopped
Drug Name	Dose	Frequency	Prescribing Physician	Reason	Date stopped
Drug Name	Dose	Frequency	Prescribing Physician	Reason	Date stopped
Drug Name	Dose	Frequency	Prescribing Physician	Reason	Date stopped
Drug Name	Dose	Frequency	Prescribing Physician	Reason	Date stopped
Drug Name	Dose	Frequency	Prescribing Physician	Reason	Date stopped

Social History

Have you been married previously?

Are you sexually active?

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How would you identify your sexual orientation/identity?
□ Heterosexual/Straight □ Bisexual □ Unsure
□ Gay/Lesbian □ Transgender □ Prefer Not to Answer

Do you have a history of abuse? If yes, select the types of abuse.
□ No History of Sexual, Emotional, Physical or Neglect

□ Sexual □ Emotional □ Physical □ Neglect

Do you exercise regularly?

Smoking Status
If a smoker, how many times during the day do you use tobacco products?

Do drink alcohol?
If yes, how many times in a week, do you drink alcohol?

Have you felt bad or guilty about your drinking?

If you are female, what is your pregnancy status?

Legal History
Do you have any pending legal problems?

Spiritual Life
Do you belong to a religion or spiritual group?

Is this involvement helpful or stressful?

Risk Assessment
Suicide Risk Assessment

1. Have you been so distressed you seriously wished to end your life?
   □ No □ Today □ Recently

2. Has anything happened recently to make you feel you don't want to live?
   □ No □ Today □ Recently

3. Do you have thoughts of hurting someone else?
   □ No □ Today □ Recently

If yes, describe the incident / event.

4. Do you have access to weapons or means of hurting self?

   □ No □ Yes

Have you had or do you have:

5. A specific plan how you would kill yourself?

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6. Made a serious suicide attempt?

7. Purposely done something to hurt yourself?

8. Heard voices telling you to hurt yourself?

9. Had relatives who attempted or committed suicide?

10. Had thoughts of killing or seriously hurting someone?

11. Heard voices telling you to hurt others?

12. Hurt someone or destroyed property on purpose?

13. Slapped, kicked, punched someone with intent to harm?

14. Been arrested or detained for violent behavior?

15. Been to jail for any reason?

16. Been on probation for any reason?

17. Do you have access to guns?

Substance Use Assessment

1. Do you think you may have a problem with alcohol or drug use?

2. Have you ever been treated for alcohol or drug abuse?

3. Have you used any street drugs in the past 3 months?

4. Have you ever abused prescription medications?

Name the substances you have tried and the date you last used them.

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Symptom Checklist
Please check any symptoms you have experiences in the past month:

□ Aggressive
□ Apathy
□ Assaultive
□ Difficulty Staying Asleep
□ Drop in Functioning
□ Frequent Crying
□ Irritability
□ Feeling Disconnected
□ Loss of Interests
□ Nervous or Suspicious
□ Mood Changes of Others
□ Paranoia
□ Peculiar or Uncharacteristic Behavior
□ Problems with Thinking/
□ Restless Concentrating
□ Withdrawal
Other (specify)

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Client Fee Agreement & Informed Consent

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 usually 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
- Clinical consultation

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

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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

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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