

**CATHOLIC CHARITIES OF THE ARCHDIOCESE OF DUBUQUE
COUNSELING PROGRAM**

SERVICE INTAKE FORM

Appointment Date: _____ Name: _____ Date of Birth: _____

Address: _____

Street City State Zip Code County

Home Phone: _____ Work Phone: _____ Cell Phone _____

Emergency Contact: _____

Name Address Phone #

Religious Preference: _____ Email Address: _____

Employer/Occupation: Self: _____ Spouse: _____

Marital Status:

Single: _____ Date Married: _____ Date Separated: _____ Date Divorced: _____ Date Widowed: _____

Racial Composition: American Indian or Alaskan Native _____ Asian or Pacific Islander _____

Black _____ Hispanic _____ White _____ Other _____

Number of Family Members in household (including self and dependents) _____

Military History: _____ Years of Service: _____ Academic History: _____

How did you find out about our services? _____

Please list additional people being seen by counselor:

Name	Sex	Date of Birth	Relationship	Education

Reason for seeking counseling (please check one): Anger Management Child behavior issues Depression Divorce issues
 Anxiety Marital Parenting issues Relationship issues Referral Court ordered Stress Abuse Addiction

List any previous counseling: _____

(Where, when and from whom)

List other agencies or providers who are assisting you: _____

Please list all prescribed medication you are using and their dosage: _____

Please list physician's name: _____

Income Source: (Please circle) Employed Self-Employed Unemployed Retired Social Security SSI

Income Range: (Please circle) A. \$0 to \$10,000 B. \$10,001 to \$20,000 C. \$20,001 to \$30,000

D. \$30,001 to \$40,000 E. \$40,001 to \$50,000 F. \$50,001 to \$

Legal Status: (Please circle) Payee CINA Commitment Guardian Power of Attorney Conservator

OFFICE USE ONLY

Staff Name: _____ **Location:** _____

Type of Payment: Sliding Fee: \$ _____ Insurance Co Pay \$ _____ EAP \$ _____

Number of People Served: _____ **Closing Date:** _____ **Transferred:** _____ **Evaluation Sent** _____