For Office Use Only

Therapist: _____
Appt Date: _____
Appt Time: _____

Catholic Charities, Inc.
CLINICAL SERVICES INITIAL CONTACT FORM
(If making a client referral, please fax to 302-654-6432, Attn: Intake Coordinator)

Date: _____ Time: _____ Staff Initials: _____

Name of Potential Client: _____

Name of Caller: _____

Contact Numbers: 1) _____ 2) _____

After your initial appointment, do you have a need for evening appointments? **Y** **N**
Other app. needs: _____

May we call you on the phone to remind you of your appointment? _____

Referral Source: _____

Is your treatment in anyway Court Ordered? **Y** **N** Reason: _____

Any current legal Issues: _____

Currently seeking disability status for MH/SA issues? _____

Previous treatment at Catholic Charities? **Y** **N** Approximate Date: _____

Reason for seeking treatment: _____

_____

_____

_____

Treatment received in last five years, if any: _____

_____

_____

Pattern of drug and alcohol use in last year, if any (what, how long, etc): _____

_____

Current Medications: _____

Past Medications: _____

Prescribed by**:** **PCP or Psychiatrist or Other**

Others who may be involved in treatment: _____

DEMOGRAPHIC and INSURANCE INFORMATION

Address: _____

_____ Zip: _____

Insurance: _____ ID# _____

SSN #_____ or DOB: _____

Subscriber if other than Client: _____

If Self-Pay, fee assessment appt scheduled or waiting list: _____

(For Office Use Only Below this line)
FOLLOW-UP CONTACTS
Summary of Contact and Date

1. _____

_____

2. _____

_____

Other Notes: _____

_____