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): ____________
______________________________________________________________________

For Office Use Only
Therapist: _______________  Appt Date: _______________  Appt Time: _______________
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: ________________________________________________________________

______________________________________________________________________________

revised 5-24-18 SM