



## Catholic Charities North Dakota Counseling Services Intake Forms and Appointment Reminder

### Reminders for you as you come in for your first appointment...

**Please complete ALL of this paperwork to the best of your abilities and bring it to your first appointment.**

**Please arrive 20 minutes before your scheduled appointment time to complete any additional paperwork.**

**Paying for Counseling Services:**

**Insurance-** We accept and work with various insurance companies. You must bring your insurance card along with you to your first appointment, so we may get a copy for your file for insurance billing purposes. You will be responsible for all costs not covered by your insurance including your annual deductible, co-pays and co-insurance.

**EAP-** If you are using an Employee Assistance Program (EAP), please call your EAP provider prior to the appointment to get an authorization number and the number of sessions that have been approved. No payment is expected from the client when utilizing an EAP.

**Self-pay -** If you do not have insurance or EAP benefits, you may pay out of pocket for your therapy. Self pay fees are due and expected at the time of service.

**Self Pay-Sliding Fee Scale -** You may utilize the sliding fee scale. The sliding fee scale is based on household income and number of dependents. Payment for self pay sessions are due and expected at the time of service.

**Self Pay-Fee Reduction -** If paying the full amount for self pay or the self pay sliding fee scale amount causes a hardship to you or your family, you may apply for a reduction in the self pay amount. Extenuation financial circumstances will be considered. To receive reduced fees, you will need to fill out an application and provide proof of income (paystub, tax return). If there are additional extenuating circumstances that you would like us to consider, please provide documentation of those circumstances (medical bills, etc) and include them on your application. All applications for reduced fees must be approved by the Director of Counseling or the Executive Director.

**24 hr. Cancellation and No Show Policy:**

If you need to change or cancel any appointments, we have a 24 hour cancellation policy. **Please call** as soon as you know you cannot keep your appointment so that you will not be charged the \$25.00 No Show Fee. We have a waiting list and need to offer these appointments to people who are waiting.

**In the event of winter weather/storms:** If local schools are closed due to inclement weather, our office will also be closed. These appointments will be rescheduled.

**Name** \_\_\_\_\_

My appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Counselor: \_\_\_\_\_



# Catholic Charities North Dakota Counseling Services Intake Summary

**Personal Information:** Please complete the **entire intake form** for **each person** coming to counseling.

Date \_\_\_\_\_

Age \_\_\_\_\_

**Referred by:**

<input type="checkbox"/> Priest Name/Parish/Bulletin _____ <input type="checkbox"/> CCND website _____ <input type="checkbox"/> EAP _____ <input type="checkbox"/> Other _____
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**GENERAL INFORMATION:**

\_\_\_\_\_  
 (Last Name) (First Name) (Middle Initial) (Maiden)

\_\_\_\_\_  
 (Address) (Apt.#) (City) (County) (State) (Zip)

\_\_\_\_\_  
 (Phone number(s) for contact purposes) home cell work  
 (Circle one) (Best time to call)

Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ Email Address: \_\_\_\_\_

Relationship Status (single, married, separated, divorced, widow/widower, other): \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Were you ever married before? \_\_\_\_\_

Years of Education: \_\_\_\_\_ Degree(s): \_\_\_\_\_

Employed?: [ ] Full-Time [ ] Part-time [ ] Unemployed Occupation: \_\_\_\_\_

Student?: [ ] Full-time [ ] Part-time Other: \_\_\_\_\_

**Medical History**

Physician(s): \_\_\_\_\_ Clinic: \_\_\_\_\_

Approximate date of last medical appointment: \_\_\_\_\_ Results: \_\_\_\_\_

Medications taken regularly: \_\_\_\_\_

Significant medical problems that apply to you or to members of your family:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you currently in counseling elsewhere? Yes No

What other counseling have you had in the past (When, therapist/clinic, for what issues):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Client Name \_\_\_\_\_

**FAMILY INFORMATION:**

Children (Please include miscarriages, abortions, placed a child for adoption, deceased and stillborn):

<u>Name</u>	<u>D.O.B.</u>	<u>School/Occupation</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Siblings (Please include deceased and **yourself** in the birth order):

<u>Name</u>	<u>D.O.B.</u>	<u>City &amp; State</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parents (Please include biological and non-biological):

<u>Name</u>	<u>D.O.B.</u>	<u>Status</u>	<u>City &amp; State</u>
_____	_____	_____	_____
_____	_____	_____	_____

**REASON FOR VISIT:**

What are the problems that bring you here?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In your opinion, what is causing the problem?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your goals for counseling:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please check any concerns that you presently have for yourself about the following:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Suicidal thoughts        | <input type="checkbox"/> Self-Injury            | <input type="checkbox"/> Alcohol/chemical use/abuse    |
| <input type="checkbox"/> Victim of physical abuse | <input type="checkbox"/> Victim of sexual abuse | <input type="checkbox"/> Victim of emotional abuse     |
| <input type="checkbox"/> Addictive behaviors      | <input type="checkbox"/> Miscarriage            | <input type="checkbox"/> Abortion                      |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Anger                  | <input type="checkbox"/> Relationship problem          |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Annulment              | <input type="checkbox"/> Intent to hurt another person |

Other (please specify): \_\_\_\_\_

**Please complete this section if someone other than the client is completing this form.**

Name \_\_\_\_\_ Relationship to client \_\_\_\_\_

Address \_\_\_\_\_

Phone numbers \_\_\_\_\_

**CCND/CS Emergency Contact Information**

Client Name \_\_\_\_\_

**In case of Emergency, who do you want us to contact?**

**Primary Emergency Contact:**

Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

**If we are unable to contact the Primary Emergency Contact, we will contact:**

Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_



**CCND/CS Appointment Reminder Preference**

**As a courtesy, we will give you a reminder contact one business day before your therapy appointment. Which do you prefer?**

Phone call at # \_\_\_\_\_  
 Can leave message     Please don't leave message

E-Mail at \_\_\_\_\_

No reminder necessary

Client Name \_\_\_\_\_



### DATA COLLECTION FORM

This optional information is used for statistical purposes. We appreciate you taking the time to complete this form. We must report on the client population that we serve.

**Client Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **County:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Gender:** \_\_\_\_\_  
**Age:** \_\_\_ 0-10 \_\_\_ 11-20 \_\_\_ 21-30 \_\_\_ 31-40 \_\_\_ 41-50 \_\_\_ 51-60 \_\_\_ 61-70 \_\_\_ 71-80 \_\_\_ 81+

**Marital Status:** \_\_\_ Single \_\_\_ Separated \_\_\_ Engaged \_\_\_ Divorced \_\_\_ Married \_\_\_ Widowed

**Household Structure:** \_\_\_ Traditional \_\_\_ Single Parent \_\_\_ Step-Family \_\_\_ Live Alone \_\_\_ Cohabiting  
\_\_\_ Live w/Roommate \_\_\_ Other (Please Specify) \_\_\_\_\_

**Household Income:** \_\_\_ 0-\$9,999 \_\_\_ \$10,000-\$14,999 \_\_\_ \$15,000-\$19,999  
\_\_\_ \$20,000-\$29,999 \_\_\_ \$30,000-\$39,999 \_\_\_ \$40,000-\$59,999  
\_\_\_ \$60,000-\$79,999 \_\_\_ \$80,000-\$99,999 \_\_\_ \$100,000+

**Occupation:**  
\_\_\_ Student \_\_\_ Homemaker \_\_\_ Retail/Sales \_\_\_ Trade/Technical \_\_\_ Food Service/Accommodation  
\_\_\_ Education \_\_\_ Professional \_\_\_ Retired \_\_\_ Transportation \_\_\_ Religious \_\_\_ Unemployed \_\_\_ Daycare  
\_\_\_ Administrative/Clerical \_\_\_ Other (Please Specify) \_\_\_\_\_

**Financial Responsibility:** \_\_\_ Self (Private Pay) \_\_\_ Insurance \_\_\_ EAP \_\_\_ Church \_\_\_ Parents  
Other (Please Specify) \_\_\_\_\_

**Do you attend a church:** \_\_\_ Yes \_\_\_ No **Church Name:** \_\_\_\_\_

**Denomination Attending:**  
\_\_\_ Catholic \_\_\_ Lutheran Brethren \_\_\_ Lutheran \_\_\_ Evangelical Free \_\_\_ Baptist \_\_\_ Methodist  
\_\_\_ Assembly of God \_\_\_ Pentecostal \_\_\_ Nazarene \_\_\_ Presbyterian \_\_\_ Non-denominational  
\_\_\_ Other (Please Specify) \_\_\_\_\_

**Referral Source:**  
\_\_\_ Church/Clergy \_\_\_ Physician \_\_\_ Professional \_\_\_ Former Client \_\_\_ Friend \_\_\_ Relative \_\_\_ Internet Search  
\_\_\_ Radio \_\_\_ Yellow Pages \_\_\_ Court \_\_\_ Other (Please Specify) \_\_\_\_\_

**Type of Counseling:** \_\_\_ Individual \_\_\_ Couple/Marital \_\_\_ Family \_\_\_ Pre-Marital \_\_\_ Group/Class

**Race/Ethnicity:** \_\_\_ White (Caucasian) \_\_\_ Black (African-American) \_\_\_ American Indian/Native Alaskan  
\_\_\_ Asian American \_\_\_ Middle Eastern \_\_\_ Hispanic/Latino \_\_\_ Prefer not to respond \_\_\_ Unknown  
\_\_\_ Other \_\_\_\_\_

**Language spoken at home:** \_\_\_\_\_ **Do you require an interpreter?** \_\_\_ yes \_\_\_ no

**Refugee:** \_\_\_ yes \_\_\_ no



## **Catholic Charities North Dakota Counseling Services** **Information and Consent Form**

Thank you for choosing Catholic Charities North Dakota Counseling Services. We hope that your experience with us is useful in addressing your concerns. This form is designed to assist you in understanding important aspects of our counseling process.

### **The Purpose of Counseling:**

Through a professional relationship with your counselor, you will be encouraged to discover your own strengths and learn helpful resources that can assist you in overcoming your challenges and struggles. Counseling often involves hard work. It requires your time, your active cooperation and your commitment.

Each of Catholic Charities counselors have a Master's Degree in Social Work, Counseling, or Marriage and Family Therapy. They are licensed in the state of North Dakota and stay current in their profession by regularly staying current with best practice in the field. Our counselors adhere to the ethical standards set by their profession. Our counselors are committed to providing competent and professional services to you.

### **Fee Policy:**

For self-paying clients, payment is expected at the beginning of each session. If you have a diagnosable mental health condition and are covered by health insurance, Catholic Charities will bill the insurance company directly. Marriage and relationship counseling is not covered by most insurance companies, but we always suggested that you call your insurance company to be certain. **It is the client's responsibility to contact their insurance company to know the extent of their coverage.** We also accept Employee Assistance Programs (EAPs). Many employers have available EAP services for their employees. Ask your employer if you are unsure if your place of employment has EAP services available for you.

**Cancellation and No Show Policy:** It is important that you arrive promptly for appointments and we ask you to contact our office if you will be late or need to reschedule your appointment. If it is necessary for you to cancel an appointment, a 24 hour notice must be given. We can then offer that time slot to another individual who is on our waiting list and in need of services. An appointment that is missed without 24 hrs. Notice is considered a No Show. If this occurs, you will be billed a No Show Fee. The standard No Show Fee is \$25.00. If two or more No Shows occur, you will not be able to reschedule an appointment without approval from the counselor. You may have to discuss these issues with your counselor to make plans to resolve this issue, as this can demonstrate that you are not currently ready to commit to therapy. It is our policy to allow only one appointment to be scheduled at a time.

**Confidentiality:** Your confidentiality will be protected with great care. However, counselors are Mandated Reporters and are required to report situations of suspected abuse or neglect of a child or vulnerable adult, potential suicidal behavior or threats towards others. In addition, in certain unusual situations, the court may subpoena counseling records.

### **After Hours Emergencies:**

#### **If you are in a crisis and need immediate assistance:**

- **Call 911, call law enforcement, or visit your local Emergency Room,**
- **Call your primary care physician,**
- **Call a suicide hotline 1-800-273-TALK (8255).**

**Terminating Treatment:** You have the right to terminate or take a break from your treatment at any time without permission or agreement. Clinicians will discuss termination and aftercare plans in your last session. If you do decide to exercise this option, we encourage you to talk with your therapist prior to terminating your treatment so that you can bring sufficient closure to your work together. In your final session, you can discuss your progress thus far and explore ways in which you can continue to utilize the skills and knowledge that you have gained throughout your therapy. You can also discuss any referrals that you may require at that time.

**Client Signature** \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

PR1.0b, ADM19.0a, CS202a

**Catholic Charities North Dakota Acknowledgement of Receipt of Privacy Notice, Client Rights and Responsibilities Brochure, and the Electronic Communications with Clients or Electronic Communications Containing Protected Health Information Policy**

Client Name: \_\_\_\_\_ File Number: \_\_\_\_\_

By signing this form, you acknowledge that Catholic Charities North Dakota has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. By signing this form, you acknowledge that Catholic Charities North Dakota has given you a copy of its CLIENT RIGHTS AND RESPONSIBILITIES BROCHURE, which explains your rights and responsibilities as a client. By signing this form, you acknowledge that Catholic Charities North Dakota has given you a copy of its Electronic Communications with Clients or Electronic Communications Containing Protected Health Information Policy, which explains how we handle various forms of electronic communication. We must try to have you sign this form on your first date of service or upon assessment for eligibility for services with us. If your first date of service with us was due to an emergency, we must try to give you this information and get your signature acknowledging receipt of this information as soon as we can after the emergency.

Check all that are true:

- I have received Catholic Charities North Dakota’s Privacy Notice, Client Rights and Responsibilities Brochure, and the Electronic Communications with Clients or Electronic Communications Containing PHI Policy.
- Catholic Charities North Dakota has given me the chance to discuss my concerns and questions about any of the provided information.

\_\_\_\_\_  
**Client’s Signature** Date

\_\_\_\_\_  
Parent/Guardian’s Signature Date

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Catholic Charities North Dakota’s staff should complete if Acknowledgement Form is not signed:

Does client have a copy of the this information?  Yes  No

Please explain why the client was unable to sign an acknowledgement form and Catholic Charities North Dakota’s efforts in trying to obtain the client’s signature:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
CCND staff signature Date



**Catholic Charities North Dakota Counseling Services**  
**Consent for Minors Form**

**Consent for Minors:** I have the legal right as parent/guardian to grant Catholic Charities North Dakota permission to provide counseling services for \_\_\_\_\_ (minor). I understand that by giving my permission to see the above minor, I have a right to consultation regarding progress and agree to cooperate with the therapist to facilitate services for this child. Counseling is for the benefit of the child/children. Special sensitivity may be required in releasing information to the parent/guardian due to the therapeutic relationship between the child and therapist. I will accept the therapist's professional judgment in regard to releasing or sharing information obtained during the course of counseling with this minor.

**Signatures:** The signatures below indicate that the client and parent/guardian understand the information contained on this form and has had an opportunity to clarify.

**Client Signature:** \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

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## **CATHOLIC CHARITIES NORTH DAKOTA**

### **Electronic Communications with Clients or Containing Protected Health Information Policy**

In order to inform clients of the inherent risks involved with any electronic communication used as a means to communicate during their treatment, CCND/CS has prepared the following policy. The use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk. Consequently, this policy addresses the security and confidentiality of client treatment.

#### **Phone Calls**

Regularly, CCND/CS uses a landline phone physically located at the CCND/CS service location. This is the preferred method of communication used by CCND/CS staff. Clinicians should not give clients their personal cell phone number.

#### **Email Communications**

CCND/CS will use email communication only with client permission. If Protected Health Information (PHI) needs to be emailed to a client or received from a client, the document may be password protected to safeguard client privacy. If the client agrees to communicate via email and would like to password protect the information, the document password would be established and instructions for password protecting documents would be shared with you.

#### **Directions to password protect a word document:**

1. Open the file you want to password protect
2. Click File on the top left menu, then Save As
3. Choose the same location or pick a different one if you want
4. On the bottom right, click Tools, then General Options
5. You may enter a password to open and/or modify
6. You may also click the box that says "Read Only Recommended"; if the person you send this to tries to make changes, they will have to save the file with a different name
7. Then click OK at the bottom and Save on the next screen

#### **Text Messaging**

Because text messaging is a very unsecure and impersonal mode of communication, we only use text message to do client appointment reminders with the client's permission. CCND/CS will only use "computer to text" applications to send the appointment reminders. CCND does not respond to text messages from anyone in treatment with a CCND/CS clinician. Clients should not text message CCND unless they have made other arrangements.

#### **CCND Website**

CCND has a website that clients are free to access. CCND uses it for professional reasons and to provide information to others about our organization and our mission. Clients are welcome to access and review the information that CCND has on our website and, if the client has questions about it, they should discuss them during their therapy sessions.

### DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Date: \_\_\_\_\_

If this questionnaire is completed by an informant, what is your relationship with the individual? \_\_\_\_\_

In a typical week, approximately how much time do you spend with the individual? \_\_\_\_\_ hours/week

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

### Brief Trauma Questionnaire

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please circle "Yes" or "No" to report what has happened to you.

If you answer "Yes" for an event, please answer any additional questions that are listed on the right side of the page to report: (1) whether you thought your life was in danger or you might be seriously injured; and (2) whether you were seriously injured.

If you answer "No" for an event, go on to the next event.

Event	Has this ever happened to you?	If the event happened, did you think your life was in danger or you might be seriously injured?	If the event happened, were you seriously injured?
1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty?)	No Yes	No Yes	No Yes
2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No Yes	No Yes	No Yes
3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill?	No Yes	No Yes	No Yes
4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?	No Yes	No Yes	N/A
5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?	No Yes	No Yes	No Yes
6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members or strangers?	No Yes	No Yes	No Yes
7. Has anyone ever made or pressured you into having some type of unwanted sexual contact? <i>Note: By sexual contact we mean any contact between someone else and your private parts or between you and some else's private parts</i>	No Yes	No Yes	No Yes
8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?	No Yes	N/A	No Yes
9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?	No Yes	N/A	No Yes
10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? <i>Note: Do not answer "yes" for any event you already reported in Questions 1-9</i>	No Yes	N/A	N/A