



**CFS Client Information Sheet**

Are You a Veteran ( Circle ) Yes or No If you receive Medicaid ( Circle ) Yes or No

Today's Date:

E-mail Address:

Last Name:		First Name:		Middle Initial:	SS#
Street Address:					
City:		State:		Zip Code:	
County:			Home Phone:		
If we need to contact you by phone regarding appointment changes, is this ok? __Yes__No				Cell Phone:	
Marital Status (Circle One):                      Single    Married    Widowed    Divorced    Separated					
Date of Birth: (month, day, year)			Age:	Race:	
Gender (Circle One) : M/F		Number of dependent children (age 19 and under) living in your home:			
Are you Employed: Yes No Work Phone: _____ If yes, place of Employment: _____			Retired: Yes No Student: Yes No		
Do you have health insurance? (Circle one)                      Medicaid                      Yes    No					
If yes, does your health insurance cover mental health? (Circle one)    Yes    No					
<b>Yearly Household Income: \$</b>					
Emergency Contact Name:			Relationship to you:		
			Emergency Contact Phone #		
Services Requested from CFS:    Counseling Services    Adoption Services    Birth Mother Other: _____					
<b>Who Referred you to CFS?</b>			Religious Preference:		
What agency is this person from?					
Fee set per session (see Fee Schedule): \$ _____ Beginning 5-1-15, any counseling client who fails to keep a scheduled appointment, without at least 24 hours' notice, will be charged a missed appointment fee. This fee will be the agreed upon fee listed above. The missed appointment fee for the psychiatrist is your normal fee of \$35. <b>We reserve the right to reschedule you if you arrive late for your appointment.</b>					
<i>Office Use Only:</i>			<i>Social Worker:</i>		
<i>Date Opened:</i>		<i>Appointment Time:</i>		<i>Date Closed:</i>	



### **Client's Rights and Responsibilities**

**WELCOME** to Catholic Family Services. Please be assured that our staff will do our utmost to be helpful to you. We offer Individual, Marriage and Family Counseling, Unplanned Pregnancy Counseling, Adoption and Child and Foster Care Services.

#### **Your Rights:**

1. You will receive competent professional services without discrimination due to race, color, creed, age, religious beliefs, national origin, economic status, sex, or disability.
2. Information will be provided to you about all our services and any questions you have will be answered in terms that you can understand.
3. You will have input into the design and implementation of an individualized treatment plan.
4. The information you disclose to Catholic Family Services about your problems is confidential. The exceptions to this are:
  - a) when child or elder abuse or neglect is suspected or reported;
  - b) when your life or the life of another person is in danger;
  - c) when a properly executed court subpoena is issued;
  - d) when The State of Alabama Code does not recognize counselor/client privilege.
5. You have the right to review, in the presence of a staff member, any information about you in the agency's records.
6. You may request a change of counselor through discussion of your request with your counselor.
7. You can refuse or change a course of treatment or terminate services with this agency unless you are ordered by law or the court, in which case, the court or a representative of the law enforcement agency will be notified of your refusal or request to change your course of treatment, or to terminate our services, and the law or the court may or may not order its approval.
8. You may address any concerns about the services you receive to the Director of Catholic Social Services.



**Your Responsibilities:**

1. To keep your appointments or to **cancel 24 hours in advance**. For clients who pay a fee, we reserve the right to charge for late cancellations or missed appointments. For clients who do not pay a fee, there will be a \$20 fee charged for repeated failure to cancel or missed appointments.
2. For Dr. Paoletti Psychiatrist appts cost is \$40 and for the counseling sliding scale. We have a two (2) no show/cancellation policy that states if you cancel or no show for two (2) consecutive appointments, your services will be terminated with Catholic Family Services effective the date of the second no show. This will also include termination with Dr. Paoletti.
3. To pay for your services at the time of your appointment or make arrangements for a delayed schedule of payment. A sliding scale fee is charged for counseling services. Fees may be reduced or waived for those unable to pay a fee. There are no fees for Unplanned Pregnancy Counseling or Foster Care. Adoptive families will receive fee information at the first appointment.
4. To be actively involved in the planning and execution of your treatment plan.

**CONDITIONS UNDER WHICH CATHOLIC FAMILY SERVICES MAY DENY FURTHER SERVICES.**

1. If you are two sessions behind in your fee payments.
2. If you have missed two appointments.
3. If you are not actively participating in your treatment plan.
4. If you display violent or threatening behavior or language.
5. If you are using mood altering substances during the course of your sessions and it interferes with your progress.
6. If it is your counselor's professional judgment that you would be better served at another agency.



7. If the nature of your symptoms indicates the need for medication and you refuse to consult a physician for assessment.

8. If you are actively involved in therapy with another therapist outside the agency who is not working cooperatively with our counselor for your benefit.

9. If you are delinquent in fees, your social worker will advise you of this and work with you on a method to remedy the situation.

10. If you are unwilling to remedy the problem, the social worker will work with you to find another resource for services.

Should you feel that your rights have not been respected, please discuss this first with your counselor.

If this does not resolve the problem satisfactorily, you may put your concern in writing to your counselor's supervisor. If you are still dissatisfied, you may write the Director of Catholic Social Services in Birmingham, and request a personal review.

The address is:

**1515 12<sup>th</sup> Ave South, Birmingham, AL, 35205**

**You will also have the right in this process to appeal to someone outside the agency to act as an advocate for you.**

**I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE CLIENT RIGHTS AND RESPONSIBILITIES.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



### COUNSELING INTAKE QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

The following questions are asked of all persons beginning counseling services. We have found the information useful because it covers areas that may be missed during early interviews. You may find some questions unrelated to yourself but answer them as best you can. All your answers will be kept confidential and will not be used outside of Catholic Family Services without your written permission.

#### **Problems and Outcomes**

Please describe briefly the problems that bring you to Catholic Family Services. Begin with the problem that seems most important for you to work on. After listing each problem, also describe the most successful outcome and the worst outcome for you regarding the problem.

Problem 1:

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What would be the best outcome for you?

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What would be the worst outcome for you?

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Problem 2:

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What would be the best outcome for you?

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What would be the worst outcome for you?

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**Problem Checklist**

Please check all items below which describe your situation today or in the past year.

**General Mood or Difficulties:**  anxious or tense  fatigued or tired  upset  sad  depressed  
 despondent  difficulty concentrating  difficulty making decisions  mood swings  sleep problems  
 appetite loss  recent loss (or gain) of weight  annoyed  angry  irritated  fearful  phobic  
 worried  lonely

Other (please explain):

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**Work:**  My work is very stressful  I do not like my job/career  I have conflicts with my boss/co-workers  
 I am unemployed  I am retired  Other (Please explain):

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**Marriage and Family:**  I have an unsatisfactory relationship with my spouse (or significant other)  
 My spouse/significant other has problems  I have an unsatisfactory relationship with my children  
 My children have problems  I have an unsatisfactory relationship with my parents  My parents have problems  
 I have an unsatisfactory relationship with my in-laws  My in-laws have problems  
 There are health problems in my family  There has been a disruption in the family due to a divorce, separation, or estrangement \_\_\_\_\_ Other  
(Please explain):\_\_

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**Health:**

I have health concerns  I feel I drink too much \_\_\_\_\_ I feel I take illegal drugs too much  
 I feel I take prescribed medication too much \_\_\_\_\_ I am unhappy with my physical appearance  
 Sometimes, I hear voices in my head  Other (Please explain):

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**Coping Skills:**  I have difficulty expressing my emotions \_\_\_\_\_ I work too much \_\_\_\_\_ I spend too much money  
 I am a perfectionist \_\_\_\_\_ I do not handle pressure well \_\_\_\_\_ At times I act or react violently  
 Other (Please explain):

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**Personal:**  I have had an unwanted sexual experience \_\_\_\_\_ I have experienced a recent emotional crisis or trauma  
 I have financial concerns \_\_\_\_\_ I have recently moved or changed jobs \_\_\_\_\_ I am having difficulty with the death (or loss) of a family member or friend \_\_\_\_\_ I feel alone  
 I have inadequate social support \_\_\_\_\_ I am having difficulty adjusting to life changes \_\_\_\_\_ I am having legal problems  
 I am a victim of crime \_\_\_\_\_ I have difficulty with relationships (example: friends, sibling, parent, spouse, significant other, teachers, classmates, etc.) Specify:

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**Have You ever had an Miscarriage (Circle) Yes/ NO**

**Have You ever had an Abortion (Circle) Yes/ NO**



     I have thoughts about, am thinking about, or have tried to (Please explain):

- Harm myself in the past
  
- Harm myself (present)
  
- Harm another person in the past
  
- Harm another person (present)

Do your feelings go quickly from one extreme to another?

     Never      Sometimes      Occasionally      Often

Do you feel people are trying to harm you or are following you?

     Never      Sometimes      Occasionally      Often

Are you bothered by thoughts or actions you cannot control?

     Never      Sometimes      Occasionally      Often

Do others feel you have a problem with drugs or alcohol?      Yes      No

How much do you believe your problems interfere with your daily ability to function? (Circle one)

None    1    2    3    4    5    6    7    8    9    10    A great deal

Do you have a primary physician?                                  If so, who?

\_\_\_\_\_

Do you have medical problems?                                  If so, please explain and include the names of all medication(s) you are currently taking, dosage, and the prescribing physician:

\_\_\_\_\_

\_\_\_\_\_





Have you ever been hospitalized for alcohol or emotional problems? \_\_\_\_ Yes \_\_\_\_ No

If yes, when and where?

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Have you ever been in counseling before? \_Yes\_ No If yes, where and when:

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Are you currently in therapy with another professional? \_\_\_\_ Yes \_\_\_\_ No

Did you find previous counseling experiences to be beneficial to you? \_\_\_\_ Yes \_\_\_\_ No

Please list any current people or groups that you feel you can count on for emotional support:

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Is there anything else you feel we should know that would help us working with you?

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### Counseling Fees

INCOME		FEE
\$0-	\$10,000	\$2
\$10,001-	\$20,000	\$5
\$20,001-	\$25,000	\$10
\$25,001-	\$30,000	\$20
\$30,001-	\$40,000	\$30
\$40,001-	\$50,000	\$55
\$50,001-	\$60,000	\$60
\$60,001-	\$70,000	\$70
\$70,001-	\$80,000	\$80
\$80,001-	AND UP	\$90
<b>Dr. Paoletti's (Birmingham-fee will be a flat rate of \$40).</b>		

I agree to pay Catholic Family Services the sliding fee scale \$\_\_\_\_\_ for **counseling sessions**.

I understand if at any time I am unable to pay the fee, I should discuss my situation with my social worker who **will have to get approval from Executive Director**.

Please sign: \_\_\_\_\_

Date: \_\_\_\_\_