CATHOLIC CHARITIES-COMMUNITY COUNSELING
APPLICATION

TODAY'S DATE ______________________________ THERAPIST ____________________

Reason for today's appointment: Individual Counseling ______ Couple/FOCCUS _____
Family __________ Groups ______

WIA _______ Pregnancy Service ______ Adoption Service ______ Search & Reunion _____

Referral Source: ____

PRIMARY CLIENT: Adult ______ Minor ______

____
Last First MI

____
Address City State Zip

DOB: _____________ M/F _______ Race:______________ SS# ______________________

Home Phone: ________________ Work Phone: _________________ Cell Phone: __________________

Marital Status ____________________ Highest Level of Education: ____________________________

Employer ____ Full time/Part time_________

Religion ____________________________ Church/Parish ____

IF MINOR: School: ____ Grade: __________________

Teacher: ____

SPOUSE OR PARENT IF PRIMARY CLIENT IS A MINOR: Spouse: ________ Parent:________

____
Last First MI

____
Address City State Zip

DOB: __________ AGE: _______ M/F _______ Race:_________ SS#_____________________

Home Phone: ________________ Work Phone: _________________ Cell Phone: __________________

Marital Status ____________________ Highest Level of Education: ____________________________

Employer ____ Full time/Part time_________

Religion ________________________ Church/Parish ____

OVER PLEASE

CATHOLIC CHARITIES-COMMUNITY COUNSELING
APPLICATION

EMERGENCY CONTACT (<u>SOMEONE NOT LIVING AT PRIMARY CLIENT ADDRESS</u>)

Name: ______________________________ Address: ___________________________________

Relationship:____________________ Employer: ____________________________________

City: _____________________________ State ______ Zip _______ Phone: ________________

Primary Care Physician ____

Address: ____ Phone: _______________________

OTHERS IN THE HOME:

Last Name, First, MI	M/F	DOB	SSN	Race	Relationship	Marital Status	Employer	Full or Part Time

<u>Annual Household Income</u>: Head of Household $_________ Spouse $_________.
Please indicate the size of your household (**<u>include dependents you are financially responsible for but do not live with you</u>**) ________.

INSURANCE INFORMATION

Primary Insurance Company ____

Name of Insured: ____

Employer: ____ ID # ____________________

Group # _______________________

Secondary Insurance Company ____

Name of Insured: ____

Employer: ____ ID # ____________________

Group # _______________________