Catholic Community Services Yuma
Counseling and Behavioral Health Services
Client Registration Form

Instructions: This form must be filled out completely by the Individual or Parent/Guardian of Minor requesting services.

_____ ☐Male ☐ Female ____/____/____
First Name **Last Name** **MI** **Sex** **Date of Birth**

Phone Number: _____ ☐Cell ☐Home **Home Address:** _____

Email Address: _____ _____

Age: _____ **Primary Language:** _____ **Preferred Language:** _____

Ethnicity: ☐Caucasian ☐Hispanic ☐African American ☐Native American ☐ Asian ☐Pacific Islander ☐Other: _____

Marital Status: ☐Single ☐Separated ☐Divorced ☐Widowed ☐ Co-habitation ☐Married (# of marriages _____)

Emergency Contact Information

Emergency Contact: _____ **Contact Number:** _____

Relationship: _____ **Address:** _____

_____

Attending Physician / Treatment Information

Medical Office Name: _____

Physician/Professional Name: _____ **Contact Number:** _____

Primary Treatment Agency: _____

Professional Name: _____ **Contact Number:** _____

Referral Information

Agency/Entity: _____ **Contact Number:** _____

Name of Individual, Position (if applicable): _____

Referral Basis: _____

Financial/Employment Information

Do you currently work? ☐Yes ☐No **If yes:** ☐ Part-time ☐ Full-time **Income:** _____ ☐Monthly ☐ Annually

Source of Income: ☐Employment ☐ Unemployment ☐ Disability ☐ Retirement ☐ Other: _____

Employer Name: _____ **Length of Employment:** _____ **Position:** _____

Payer Source

☐ **Private/Self Pay:** Proof of income must be provided to determine session fees according to the Sliding Fee Scale.

☐ **Insurance Company:** Insurance Company Name: _____

Insured's Name: _____ Date of Birth: ____/____/____

Social Security Number: _____ Employer: _____

Policy #: _____ Member ID: _____ Group #: _____

Note: We will bill your insurance company. Billing not covered by Insurance company will be directly billed to the Responsible Party.

☐ **Third Party Payer*:** Name: _____ Contact Number: _____

Relationship: _____ Email: _____

Billing Address: _____

*Client must sign a release of information for session dates and duration for billing purposes.

☐ **AHCCCS:** Member Name: _____ Contact Number: _____

DOB: ____/____/____ AHCCCS ID#: _____ CIS#: _____

Client Name: _____ Client ID: _____

This section will capture general information about you or the person requesting services.

Are you at risk of extreme weather conditions like heat or cold, without the ability to access appropriate shelter? ☐No ☐Yes

Describe your living situation: ☐Stable/Have secure housing ☐Constant moving ☐Staying overnight at different homes ☐ Staying at a local shelter ☐ Homeless

List Individuals who live in the Household

Name	Age	Sex	Relationship	Quality of Relationship
		☐ Male ☐ Female		☐ Good ☐ Average ☐ Poor
		☐ Male ☐ Female		☐ Good ☐ Average ☐ Poor
		☐ Male ☐ Female		☐ Good ☐ Average ☐ Poor
		☐ Male ☐ Female		☐ Good ☐ Average ☐ Poor
		☐ Male ☐ Female		☐ Good ☐ Average ☐ Poor
		☐ Male ☐ Female		☐ Good ☐ Average ☐ Poor
		☐ Male ☐ Female		☐ Good ☐ Average ☐ Poor
		☐ Male ☐ Female		☐ Good ☐ Average ☐ Poor
		☐ Male ☐ Female		☐ Good ☐ Average ☐ Poor

Primary Reason(s) for Seeking Services

☐Problems at School ☐Economic Challenges ☐Social Problems ☐Problems at Work ☐Problems at Home
☐Acculturation Challenges ☐Addictive Behaviors ☐Adjusting - New Job ☐Adjusting – Life Change
☐Adolescent Behavioral Problems ☐Alcohol/Drugs ☐Anger Management ☐Anxiety
☐Appetite Unusual or Poor ☐Bereavement/Grief ☐Challenges with Peers ☐Child Conflict
☐Coping with Stressors ☐Couples Conflict ☐Depression ☐Difficulty Managing Life
☐Domestic Violence ☐Eating disorder ☐Failing in School ☐Family Concerns
☐Fear/Phobias ☐Gambling ☐Hyperactivity ☐Infertility
☐Marital Conflict ☐Mental Confusion ☐Parent/Child Conflict ☐Relationship Difficulties
☐Sexual Concerns ☐Sleeping Problems ☐Social Rejection ☐Unresolved Trauma
☐Victim of Crime ☐Other: ____

Behavioral/Emotional

Please check any of the following that has been experienced by you or the person requesting services, in the **past two months**:

☐Affectionate ☐Aggressive ☐Angry ☐Anxiety ☐Avoidance
☐Bedwetting ☐Bullying ☐Carelessness ☐Clumsy ☐Confidence
☐Cutting ☐Cyber Addiction ☐Defiant ☐Depression ☐Destructive
☐Difficulty Concentrating ☐Difficulty speaking ☐Dizziness ☐Enthusiastic ☐Excessive Affectionate
☐Excessive Phone Use ☐Excessive Tablet Use ☐Feelings of failure ☐Fatigue ☐Flashbacks
☐Frustrated easily ☐Hallucinations ☐Helplessness ☐Hurting animals ☐Homicidal threats
☐Imaginary friends ☐Impulsive ☐Irritable ☐Learning problems ☐Lying
☐Loner/Isolation ☐Low self-esteem ☐Moodiness ☐Nightmares ☐Obsessive Thoughts
☐Often sick ☐Oppositional ☐Panic attacks ☐Poor appetite ☐Quarrels
☐Sadness ☐Selfie-Obsessed ☐Selfishness ☐Separation anxiety ☐Sets Fires
☐Sexual addiction ☐Sexual acting out ☐Sleeping problems ☐Soiling ☐Suicidal attempts
☐Suicidal threats ☐Talking back ☐Teeth grinding ☐Thumb sucking ☐Unsafe behaviors
☐Unusual thinking ☐Weight gain ☐Weight loss ☐Withdrawn ☐Worries excessively
☐Other: ____

Employment/Occupational

In order to better understand your present/past employment, please answer the following questions:

Have you ever been a Farmworker? ☐ No ☐ Yes Have you ever been in the Military? ☐ No ☐ Yes

Have you ever been in Public Safety? ☐ No ☐ Yes

☐N/A – Person requesting services is not employed ☐N/A – Person requesting services has never been employed

Client Name: ______________________________ Client ID: ____________________

Relationships/Support System

Who are the people that you turn to for support? _____

_____

What are the things you enjoy or have enjoyed doing? _____

_____

What do you most value in your life and why? _____

_____

Guardianship Status

☐This section is Not Applicable for the adult seeking services.

In an effort to ensure all appropriate parties are involved, identify the current Custody/Guardianship of the person seeking services and have a Birth Certificate or Court Order identifying Guardianship:

☐**Single Parent.** There is no contact with the Other Parent (supplemental form One Parent Consent required)

☐**Parents are living together (Co-Habitating) and unmarried.** Parents must sign "Consent to Treatment for Minor;" If the other Parent is unavailable, then the supplemental form is required.

☐**Parents are Married.** Both Parents must consent to treatment, and both Parents must sign, "Consent to Treatment for Minor." If the other Parent is unavailable, then the supplemental form is required.

☐**Parents are Divorced.** Parent seeking services for minor has the following Custody: ☐Sole ☐Joint

- ***Parent with Sole Custody***, a copy of a valid Court Order signed by the Judge must be provided for the Minor's Clinical Record. The Parent with Sole Custody must sign "Consent to Treatment for Minor."
- ***Parents who share Joint Custody***, a copy of a valid Court Order signed by the Judge must be provided for the Minor's Clinical Record. Both Parents must sign "Consent to Treatment for Minor." If the other Parent is unavailable, then the supplemental form is required.

The appointment for treatment services cannot be honored, unless the required consent is obtained for Minors.

☐**Legal Guardian.** Minor is under the care of a Legal Guardian; documentation must be provided.

☐Minor is a Ward of Court (DES Legal Guardian)

☐The person seeking services is an adult and there is a current Court Order in place: ☐ Medical Power of Attorney ☐ Guardianship

The appointment for treatment services cannot be honored, unless a valid Court Order signed by the Judge is provided, and the consent is signed by the Person with the Authority to Consent for care or Legal Guardian.

Appointment Notifications

The agency has an automated appointment notification system in place, that specify the Provider Name, Date, Time, Address or Phone Number of your next appointment. How will you like your appointment reminders to be sent:

☐ Phone ☐ Text ☐ Email (More than one option can be selected)

Catholic Community Services of Southern Arizona (CCSSA), Inc. hereby agrees that it will comply with the provisions set forth by the Civil Rights Act of 1964 that states: Title VI prohibits discrimination on the basis of race, color or national origin under any program or activity receiving federal financial assistance. Employment discrimination is covered by Title VI if the primary objective of the financial assistance is the provision of employment or where employment discrimination causes discrimination in providing services under such programs. Title VII prohibits discrimination in employment on the basis of race, color, religion, sex or national origin. In certain instances, differential treatment is allowed for religion, sex, or national origin if it is a bona fide occupational qualification. Sexual harassment is also prohibited under this law as are all forms of harassment based on membership in a protected class.

CCSSA, Inc. hereby agrees that it will comply with the provisions set forth by the Title VI Prohibition Against National Origin Discrimination that. This federal law prohibits discrimination based on a person's national origin, race, color, religion, disability, sex, and familial status. Laws prohibiting national origin discrimination make it illegal to discriminate because of a person's birthplace, ancestry, culture or language. This means people cannot be denied equal opportunity because they or their family are from another country, because they have a name or accent associated with a national origin group, because they participate in certain customs associated with a national origin group, or because they are married to or associate with people of a certain national origin.

Completed by: _____ Date: _____

Client Name: _____ Client ID: _____