**DIONNE CATLEDGE, LCSW**
*Licensed Clinical Social Worker*

*1122 Westgate Street, Suite 203A & B, Oak Park, IL 60301*
*Phone: 708-369-0653 Fax: 708-469-4718*

Group Intake Form

| Name: (first, middle initial, last) *Please Print* | | Date of birth: |
|---|---|---|
| Address: | City, State: | Zip Code: |
| Ok to leave message? Yes☐ No☐<br><br>Home Phone:<br><br>Mobile:<br><br>Other:<br><br>Email: | | |
| Marital Status:<br>Single☐ Married ☐ Separated ☐ Divorced ☐ Widowed☐ | | |
| Have you ever participated in individual or group therapy? No☐ Yes☐ What was your experience? | | |
| Do you have children? No☐ Yes ☐ Age range? | | |
| Do you have any health concerns that impact your mental/emotional health? | | |
| Have you experience any of the following:<br><br>• Intimate partner abuse/domestic violence☐<br>• Child abuse (any form)☐<br>• Sexual assault ☐<br>• Drug addiction ☐ Sobriety history/Amount of time sober or still actively using?<br><br>• Alcohol abuse or dependence ☐Sobriety history/Amount of time sober or still actively using?<br><br>• Sexual addiction☐ Sobriety history/Amount of time sober or still actively using?<br><br>• Church/religious abuse ☐<br>• Infidelity in marriage ☐<br>• Financial abuse ☐<br>• Anything else? | | |

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|---|
| Mental health Concerns?<br><br>• Depression: Mild☐ Moderate☐ Severe ☐<br>• Anxiety☐<br>• Trauma experience: Military ☐ Childhood Abuse ☐Sexual Assault ☐ Witness a Crime☐ Victim of Crime☐ Serious Accident☐<br>• Bipolar Disorder Type:<br>• Suicide Ideation: Without plan☐ With plan, please explain:<br>• Suicide Attempt ☐ When?<br>• Homicide Ideation: Without plan☐ With plan, please explain:<br>• Homicide Attempt☐ When?<br>• Personality disorder ☐Type:<br>• Obsessive behaviors ☐Type:<br>• Compulsive behaviors ☐Type:<br>• Delusional disorders ☐Type:<br>• Hallucinations ☐Type:<br>• Impulse control disorders☐<br>• Anger management concerns☐<br>• Other? |
| Are you currently under a psychiatrist care or taking psychiatrist medication? No ☐ Yes☐<br>Type of medication: |
| Are you currently seeing an individual therapist or counselor? No☐ Yes☐<br><br>(If you want your therapist to be aware of your participation in this group, a consent to release information must be signed.) |
| How do you hope this group can be helpful to you? |

Payment information continued on next page.

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Payment for each session is due the day of each group. Payment forms accepted are cash or credit/debit only. Cards accepted: Master Card, Visa, Discover Card, or American Express. If your company allows it, you may use your Flex Spending account if it has the one of the above credit logos. Future payments are not accepted.

If you want your insurance to be used please complete the following information. Please note that if your insurance provider rejects the claim you remain responsible for payment. Insurance providers accepted: **Cigna, UHC, UBH**, **BCBS PPO**, and **Aetna**.

*Ability to use insurance must be verified prior to starting the group.*

Verify my insurance? ☐Yes ☐ No (If yes, please complete and provide a copy of your insurance card to your clinician)

PRIMARY INSURANCE

Insurance Company:

Insured's Name:

Insured's Employer:

Treatment Authorization #:

Insured's Identification #:

Group Identification #:

Insured's date of birth:

Insured's phone number:

Insured's email contact:

Client's relationship to insured: ☐Self ☐ Spouse ☐ Child

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***Confidentiality: All information gathered on this form is confidential except in cases of child or vulnerable persons exploitation, neglect, or abuse; homicidal plan; or suicidal plan. Information gathered on this form cannot be shared with any other party unless the provider is given written consent to do so.***