



Client Information

Full name: _____

First

Middle

Last

Head of household: Yes No

Street address: _____

City: _____ State: _____ Zip code: _____

County: _____

Home phone: _____

Work phone: _____ (ext) _____

Cell/pager: _____

Email: _____

Nickname: _____

Birth date: _____

SSN: _____

Education: Less than HS HS/GED Some college College degree

Marital status: Single Married Divorced

Race: Black White Hispanic Biracial Other

Sex: Female Male **Consent:** No Yes (to be completed by counselor)

Estimated household monthly income: \$ _____

Does the client have medical insurance? No Yes **Insurance Co.:** _____

Family Information (Head of Household, spouse, or significant other)

Full name: _____

First

Middle

Last

Same address as client: Yes No **Relationship:** _____

Street address: _____

City: _____ State: _____ Zip code: _____

County: _____

Home phone: _____

Work phone: _____ (ext) _____

Birth date: _____ SSN: _____

Sex: Female Male **Head of household:** Yes No

Education: Less than HS HS/GED Some college College degree

Marital status: Single Married Divorced

Race: Black White Hispanic Biracial Other

Service recipient: No Yes

Others within Household

Full name: _____	_____	_____	_____
Race: B W H Bi O Service recipient: <input type="checkbox"/> No <input type="checkbox"/> Yes	DOB	Relationship	Sex
Full name: _____	_____	_____	_____
Race: B W H Bi O Service recipient: <input type="checkbox"/> No <input type="checkbox"/> Yes	DOB	Relationship	Sex
Full name: _____	_____	_____	_____
Race: B W H Bi O Service recipient: <input type="checkbox"/> No <input type="checkbox"/> Yes	DOB	Relationship	Sex
Full name: _____	_____	_____	_____
Race: B W H Bi O Service recipient: <input type="checkbox"/> No <input type="checkbox"/> Yes	DOB	Relationship	Sex
Full name: _____	_____	_____	_____
Race: B W H Bi O Service recipient: <input type="checkbox"/> No <input type="checkbox"/> Yes	DOB	Relationship	Sex
Full name: _____	_____	_____	_____
Race: B W H Bi O Service recipient: <input type="checkbox"/> No <input type="checkbox"/> Yes	DOB	Relationship	Sex

TO BE COMPLETED BY CORNERSTONE STAFF

CFF Client ID #: _____ Program: _____ Staff name: _____

Date of initial contact of client or referral source with agency: _____ Opening date: _____

- Company (EAP only): N/A Ceridian Corporate Health International (CHI) Central Schools
 Magellan Behavioral Health (MBH) Workplace Solutions MHN UBH New Directions AFSCME
 Mercantile _____ (location) Other _____ Value Options

Referral source:

- | | |
|--|-----------------------------------|
| <input type="checkbox"/> DCFS | <input type="checkbox"/> Employer |
| <input type="checkbox"/> Family/Friend | <input type="checkbox"/> IDHS |
| <input type="checkbox"/> In-house | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Medical personnel | <input type="checkbox"/> Other |
| <input type="checkbox"/> School | <input type="checkbox"/> Self |

Permanency goal:

- Remain in home
- Return to family
- Independence
- Other
- N/A (adult)

Child welfare status at program opening:

- N/A
- MRAI
- Abuse/neglect

Juvenile Justice status at program opening:

- Arrested
- Delinquency Adjudication
- Informal Supervision
- MRAI Adjudication
- N/A
- Other

Referral reason:

- | | | |
|--|---|--|
| <input type="checkbox"/> Abuse / neglect | <input type="checkbox"/> Adoptions issues | <input type="checkbox"/> Anger control |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Grieving |
| <input type="checkbox"/> Guardianship | <input type="checkbox"/> Housing Problems | <input type="checkbox"/> Hyperactivity / impulsivity |
| <input type="checkbox"/> Legal problems | <input type="checkbox"/> Lock out | <input type="checkbox"/> Other |
| <input type="checkbox"/> Parenting Skills | <input type="checkbox"/> Pregnant or suspect pregnant | <input type="checkbox"/> Problems at work |
| <input type="checkbox"/> Relationship issues | <input type="checkbox"/> Runaway | <input type="checkbox"/> School issues |
| <input type="checkbox"/> Self-esteem issues | <input type="checkbox"/> Visitation | |

Database entry date: _____	Entry initials: _____
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