

**SAMARITAN COUNSELING SERVICES OF THE GULF COAST**

**CLIENT INTAKE INFORMATION FORM**

Client ID# \_\_\_\_\_

The information requested on this form will be kept confidential, and will help your counselor assist you. Please fill out the form as completely as you can. Use an "X" to indicate your choices.

**GENERAL INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Male \_\_\_\_\_ Female \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_  
SS## \_\_\_\_\_  
Street Address \_\_\_\_\_ Apt # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home (\_\_\_\_) \_\_\_\_\_ Work Telephone (\_\_\_\_) \_\_\_\_\_ Other (\_\_\_\_) \_\_\_\_\_  
Guardian/parent (if under 18) \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Religious/denominational preference \_\_\_\_\_  
Your congregation/church/temple \_\_\_\_\_  
Your racial/ethnic identity: \_\_\_\_\_

**Employment/Education/School Information**

Full time \_\_\_\_\_ Part-time \_\_\_\_\_ Stay at Home \_\_\_\_\_ Retired \_\_\_\_\_ Unemployed \_\_\_\_\_  
Employer/School \_\_\_\_\_ Length of Employment \_\_\_\_\_  
Type of work you do \_\_\_\_\_  
Highest Level of Education Completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+

**FAMILY INFORMATION**

Relationships: U Single U Engaged U Married U Separated U Divorced U Widowed U Partnered Partner's Name \_\_\_\_\_  
Names and ages of Children: \_\_\_\_\_

**In order for us to bill your insurance company we will need yours/or the policy holder's Social Security Number and date of birth.**

**PAYMENT METHOD**

Party responsible for payment, if other than client: Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone # \_\_\_\_\_  
Do you plan to file for insurance reimbursement? \_\_\_\_\_ Yes \_\_\_ No \_\_\_ Don't know \_\_\_\_\_  
Are you covered by an Employee Assistance Program? \_\_\_ Yes \_\_\_ No \_\_\_ Don't know  
Do you wish to apply for fee assistance? \_\_\_ Yes \_\_\_ No

Name of Ins. Co _____	Policyholder's Name _____
Ins. Co. Phone # _____	Policyholder's Birth Date _____
Address of Ins. Co. _____	Policyholder's Soc. Sec. # _____
Certificate or Policy # _____	Patient Relationship to Policyholder _____
Group Name _____	Policyholder's Employer _____
	Group # _____

**CLIENT INTAKE INFORMATION FORM (page 2)**

**PROBLEM DEFINITION**

What is your reason for seeking help now?

Are any of the following conditions a problem to you at this time? (Check the ones that apply)

<input type="checkbox"/> Anxiety
<input type="checkbox"/> Grief
<input type="checkbox"/> Depression
<input type="checkbox"/> Irrational fears
<input type="checkbox"/> Nervousness
<input type="checkbox"/> Loneliness
<input type="checkbox"/> Anger
<input type="checkbox"/> Marriage problems
<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Loss of work/job

<input type="checkbox"/> Self esteem
<input type="checkbox"/> Stress
<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Chronic fear
<input type="checkbox"/> Guilt feelings
<input type="checkbox"/> Suicidal feelings
<input type="checkbox"/> Loss of hope
<input type="checkbox"/> Rage
<input type="checkbox"/> Relationship to parents
<input type="checkbox"/> Relationship to children

<input type="checkbox"/> Loss of meaning in life
<input type="checkbox"/> Loss of faith in God
<input type="checkbox"/> Conflicts at work
<input type="checkbox"/> Religious doubts
<input type="checkbox"/> Other (list)

What would you like to see happen as a result of psychotherapy or counseling? \_\_\_\_\_

Have you received psychotherapy or counseling in the past?  Yes  No When?

Name of treating therapist: \_\_\_\_\_

**MEDICAL/PSYCHOLOGICAL HISTORY**

Name of your physician: \_\_\_\_\_

When was your last medical examination? \_\_\_\_\_

Allergies \_\_\_\_\_

Medical Problems:	Current Medications:	Managed by:
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Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

I authorize the release of information necessary to process insurance claims filed on my behalf. I assign payment of insurance benefits to Samaritan. I know that I am financially and legally responsible for payment of services rendered whether or not my health insurance covers the services rendered.

CLIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**ACKNOWLEDGEMENT:** Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

CLIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_