Samaritan Counseling Center of West Texas, Inc.

Client Intake Information

Thank you for choosing Samaritan Counseling Center of West Texas for your care. Please complete the following form entirely. This information will aid your therapist in your care. You may use the back of this form for any additional information you feel is important to communicate. Please fill out a form for each person who will participate in your session.

First Name _____ Middle Initial _____ Last Name_____

Birth Date _____/_____/_____ Age _____ Gender _____M _____F Soc Sec # _____/_____/_____

Address _____ City_____ St. _____ Zip _____

Email Address _____ Mailing Address (if different from above) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Which number is best to use in order to contact you and leave a message? _____

Name of Your Primary Care Physician _____ Psychiatrist _____

Please complete the following information required by our grant funding:

Are you a military person: ____ Current Active Duty ____Veteran ____Family Member ____No
If you are, have you or a family member been: _____Previously deployed to Iraq/Afghanistan
_____Currently deployed to Iraq/Afghanistan

Your Ethnicity: _____African-American _____Asian _____Caucasian _____Hispanic/Latino(a) _____Native-American
____Other: _____

Annual Household Income $_____ Number living in your household _____

INSURANCE Information – we will need a copy of your current card and ID.

Primary Insurance Co. _____ Member ID#_____ Group# _____
Policy Holder Name _____ Policy Holder Date of Birth _____/_____/_____
Policy Holder Social Sec. #_____/_____/_____

Secondary Insurance Co. _____ Member ID#_____ Group# _____
Policy Holder Name _____ Policy Holder Date of Birth _____/_____/_____
Policy Holder Social Sec. #_____/_____/_____

Will someone other than the client be responsible for the cost of the session? Yes No If yes, then who?
First Name_____ Middle Initial _____ Last Name _____
Birth Date _____/_____/_____ Age_____ Gender _____M _____F Soc Sec# _____/_____/_____
Address _____ City _____ St. _____ Zip _____

Insured or Responsible Party Signature: I consent and I authorize the Samaritan Counseling Center of West Texas to release medical or other supporting information necessary to process my insurance claims and/or for the collection of payment for services from the above person/organization/company. I authorize payments of medical benefits to the Samaritan Counseling Center of West Texas. However, I understand I am responsible for all deductibles and co-pays. I understand that I will be responsible for 100% of my charges should insurance not compensate the Center for my sessions. All charges and co-pays are payable and due at the time of service.

Printed Name_____ Signature_____ Date _____

FAITH/SPIRITUALITY

Samaritan Counseling Center of West Texas is a faith-based organization and we believe that by including the client's faith as a part of the therapeutic process, therapy is enhanced. It is our philosophy to work within the faith framework of the client. The Center's therapists do not impose their personal beliefs upon clients; rather, they honor the client's right to choose their own belief system.

[ ] I chose Samaritan Counseling Center due to it's faith-based perspective.

[ ] I would prefer not to complete the section below and do not want my spirituality to be addressed as a part of my discussions in therapy.

If you currently attend worship, which church/synagogue/temple do you attend? _____

How long have you attended there? _____

In your lifetime, how many years have you attended? [ ] 0-2 years [ ] 3-5 years [ ] 6 – 10 years [ ] 6-10 years [ ] Over 10 years

In childhood, did you attend a church/synagogue/temple? [ ] Yes [ ] No

Have you been a part of other denominations in the past? [ ] Yes [ ] No

Please list those denominations: _____

Please check in faith/spiritual concerns you may have:

[ ] Spiritual hunger [ ] Loss of faith [ ] Faith differences with partner/family

[ ] Moral dilemma [ ] Feelings of guilt [ ] Inability to feel forgiveness/forgive

[ ] Religious doubts [ ] Anger at God [ ] Confusion about values

[ ] Painful religious history. Please Explain: _____

Others concerns: _____

Which of the following do you actively participate in or receive support from?

[ ] Personal prayer [ ] Congregational support [ ] Spiritual or Bible reading

[ ] Support from clergy [ ] Spiritual direction [ ] Small groups at church

[ ] Bible Study [ ] Spiritual Disciplines: (please describe) _____

_____

At your request, our therapists can include faith, values and spiritual concerns in the counseling process. Please check the items below that could add value to your therapeutic experience.

[ ] Pray at the beginning of sessions [ ] Pray at the end of sessions

[ ] Use Biblical and/or faith examples [ ] Recommend religious or spiritual readings

[ ] Recommend spiritual growth activities [ ] Share personal faith perspectives when appropriate.

Other ideas for integrating faith into my therapy: _____

_____

ADULT PSYCHOSOCIAL HISTORY (18yo+)

Briefly describe the reason for seeking counseling at this time:

_____

_____

_____

_____

_____

CURRENT SYMPTOM CHECKLIST: Please mark all that apply for you occurring **in the past 2 weeks**

[ ] Depressed Mood
[ ] Appetite Problems
[ ] Sleeping too Much/Little
[ ] Low Energy
[ ] Poor Concentration
[ ] Mood Swings
[ ] Agitation
[ ] Overly Emotional
[ ] Anxiety/ Nervousness
[ ] Panic Attacks
[ ] Obsessions/Compulsions
[ ] Over Eating
[ ] Under Eating
[ ] Anorexia
[ ] Paranoid Thoughts
[ ] Suicidal Thoughts
[ ] Not in touch with reality
[ ] Delusions
[ ] Hallucinations
[ ] Aggressive Behavior
[ ] Sexual Dysfunction
[ ] Grief/Loss
[ ] Feeling Hopeless
[ ] Feeling Worthless
[ ] Isolation/Withdrawal
[ ] Guilt
[ ] Excessively Happy
[ ] Substance Abuse
[ ] Past Issues
[ ] Other: _____

EMOTIONAL/PSYCHIATRIC HISTORY

[ ] [ ] Have you ever sought counseling before?
No Yes If yes, when and where:

Prior provider name	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____
_____	_____	_____	_____

[ ] [ ] Have you ever received inpatient treatment for a psychiatric, emotional, or substance use disorder?
No Yes

If yes, on _____occasions. Longest treatment at _____ from __/_____ to ____/_____
Name of facility Month/Year Month/Year

[ ] [ ] Have you ever taken medication for a mental health or psychiatric issue? (Example: Anxiety, Depression, Bipolar, Schizophrenia…)
No Yes If Yes: Please List Medication and Dosage, Frequency, and Side Effects for each.

1) _____ Start Date:_____ End Date _____
2) _____ Start Date:_____ End Date _____

Is there any family history of psychiatric, emotional, or substance use disorders? If yes, who: _____
_____

PERSONAL HISTORY: Please mark all that apply for **YOU** currently

Current Marital status:
[ ] single, never married
[ ] engaged ___ months
[ ] married for ____ years
[ ] divorced for ___ years
[ ] separated for ___ years
[ ] divorce in process ___ months
[ ] live-in for ___years
[ ] ____ prior marriages (self)
[ ] ___ prior marriages (partner)

Intimate relationship:
[ ] never been in a serious relationship
[ ] not currently in relationship
[ ] currently in a serious relationship

Relationship Satisfaction:
[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

List children not living in same household as patient:

_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

Frequency of visitation of above: _____

MEDICAL HISTORY (check all that apply for client)

Describe your current physical health: [ ] Good [ ] Fair [ ] Poor

Primary Care Physician Name (if any): _____ Phone Number: _____

Psychiatrist Name (if any): _____ Phone Number: _____

List any medications currently being taken (give dosage & reason):

_____ _____
_____ _____
_____ _____

SUBSTANCE USE HISTORY (check all that apply for client)

Substances used (report for self):

(complete all that apply)	**First usage**	**Last usage**	**Current Use (Yes/No)**	**Frequency**	**Amount**
[ ] alcohol	_____	_____	_____	_____	_____
[ ] amphetamines/speed	_____	_____	_____	_____	_____
[ ] barbiturates/downers	_____	_____	_____	_____	_____
[ ] caffeine	_____	_____	_____	_____	_____
[ ] cocaine	_____	_____	_____	_____	_____
[ ] crack cocaine	_____	_____	_____	_____	_____
[ ] hallucinogens (e.g., LSD)	_____	_____	_____	_____	_____
[ ] inhalants (e.g., glue, gas)	_____	_____	_____	_____	_____
[ ] marijuana or hashish	_____	_____	_____	_____	_____
[ ] nicotine/cigarettes	_____	_____	_____	_____	_____
[ ] PCP	_____	_____	_____	_____	_____
[ ] prescription	_____	_____	_____	_____	_____
[ ] other _____	_____	_____	_____	_____	_____

Personal Drug/ Alcohol Treatment history:

[ ] Have you ever received outpatient treatment for drug/alcohol abuse? [ ] Y [ ] N If Yes, at what age(s)? _____
[ ] Have you ever received inpatient treatment for drug/alcohol abuse? [ ] Y [ ] N If Yes, at what age(s)? _____
[ ] Have you ever participated in a 12-step program? [ ] Y [ ] N If Yes, when? _____
[ ] Is there a family history of drug/alcohol abuse? [ ] Y [ ] N If Yes, who? _____

SOCIO-ECONOMIC HISTORY (check all that apply for client)

Living situation:
[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional

Social support system:
[ ] supportive network
[ ] few friends
[ ] substance-use-based friends
[ ] no friends
[ ] distant from family of origin

Sexual history:
[ ] heterosexual orientation
[ ] homosexual orientation
[ ] bisexual orientation
[ ] currently sexually active
[ ] currently sexually satisfied
[ ] currently sexually dissatisfied
[ ] age of first sexual experience _____
[ ] age first pregnancy/fatherhood ____
[ ] history of promiscuity age ___ to ___
[ ] history of unsafe sex age __ to ____
Additional information: _____

Military history:
[ ] never in military [ ] served in military

Employment:
[ ] employed and satisfied
[ ] unemployed
[ ] coworker conflicts
[ ] supervisor conflicts
[ ] employed but dissatisfied

Legal history:
[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment
[ ] jail/prison ____ time(s)

My Strengths: _____

_____

My areas in need of improvement: _____

_____