Samaritan Center, Inc.

Adult Client Intake Information

Thank you for choosing Samaritan Center for your care. Please complete the following forms entirely. This information will aid your provider in your care.

First Name _____ Middle Initial_____ Last Name _____

Birth Date _____ Age_____ Gender _____M _____F Soc Sec # _____

Address _____ City/State _____ Zip _____

Email Address _____

Cell Phone _____ May we leave messages on this phone? Y N

Work Phone _____ May we leave messages on this phone? Y N

Home Phone _____ May we leave messages on this phone? Y N

Occupation _____ Employer_____

Highest Level of Education _____ Marital Status_____

Emergency Contact:

Name _____ Relationship to you_____ Phone_____

Primary Care Physician _____ Phone _____

Please complete the following information required by our grant funding:

Have you served in the military ____ Active Duty ____ Veteran ____ Family Member ____ No

Ethnicity ____ African American ____ Asian ____ Caucasian ____ Hispanic/Latino(a)

____Native-American ____ Other: _____

Annual Household Income $_____ Number living in your household_____

Insurance Information (Please provide a copy of your current card and picture ID at 1st appointment)

Primary Insurance Co._____ Member ID# _____ Group# _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder Social Sec. # _____

Secondary Insurance Co. _____ Member ID# _____ Group# _____

Primary Insurance Co._____ Member ID# _____ Group# _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder Social Sec. # _____

Financially Responsible Party (Complete if NOT self, client is a minor, or the main policy holder

First Name _____ Middle Initial_____ Last Name _____

Birth Date _____ Soc Sec # _____ Relationship to client _____

Address _____ City/State _____ Zip _____

Phone _____

Preferred Pharmacy

Pharmacy Name _____ Phone _____

Address _____

Insured or Responsible Party Signature: I consent and authorize Samaritan Center 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 Center. 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 treatment. All charges and co-pays are payable and due at the time of service.

Printed Name _____ Signature _____ Date _____

Mental Health Intake Form

Name of Client: _____

How were you referred to the Center? ____ Physician ____ Employer ____ Other _____

Do you wish for your provider to contact your referral person regarding today's visit? ___Y ___N

If yes, person's name, address, and phone_____

What brings you in to see a provider (current stressors, issues, symptoms)?

_____
_____
_____

Do you have any goals for treatment? _____

_____

Please list all persons who you currently live with and their relationship to you:

_____
_____
_____

Psychiatric History

Do you have a history of mental health problems, or hospitalization? ___Y ___N

If yes, please complete the following:

Previous Diagnosis_____

Previous Hospitalization (Date and reason for hospitalization) _____

_____

Previous outpatient psychiatric treatment including counseling (including date, provider, interventions, and did you find treatment beneficial) _____
_____
_____

Are you currently prescribed or have you ever taken any medications for mental health? ___Y ___N

If yes, please provide the name, dosage, dates of use, and how helpful they were if able to recall.

_____
_____
_____
_____

Are you currently experiencing any of the following symptoms in the past 2 weeks (mark all that apply)

[] Low Mood [] Anxiety/ Nervousness [] Not in touch with reality [] Isolation/Withdrawal

[] Panic Attacks [] Guilt [] Feeling Hopeless [] Feeling Worthless [] Suicidal Thoughts

[] Sleeping too Much/Little [] Obsessions/Compulsions [] Hallucinations [] Excessively Happy

[] Low Energy [] Over Eating [] Aggressive Behavior [] Substance Abuse [] Overly Emotional

[] Poor Concentration [] Under Eating [] Sexual Dysfunction [] Mood Swings [] Grief/Loss [] Irritable

[] Paranoid Thoughts [] Other: _____

Suicide Risk Assessment

If you are currently having thoughts of suicide, there is hope. Please call or text the crisis hotline at 988, visit your nearest emergency room, or let someone know. There is help.

Do you currently, or have had in the past have feelings or thoughts that you do not want to live or that you want to kill yourself? ___Y ___N ___Current ___Past

If you have checked yes to current thoughts, please answer the following (If no, please go to family history section):

Do you have a plan _____

On a scale of 1-10 (10 being the strongest) how strong is your desire to kill yourself? _____

Has anything happened recently to make these thoughts stronger? _____

_____

What do you think would decrease your desire or stop you? _____

_____

If you could look into the future, what do you feel you could look forward to? _____

_____

Family History:

Has anyone in your family been diagnosed or treated for a mental health condition? ___Y ___N

If yes, please provide any details you may have including diagnosis, relationship to you, medications and if they were effective. _____

_____

_____

Does anyone in your family (grandparents, parents, siblings, children) have any medical issues? __Y __N

If yes, please provide details including what medical issue, person's relationship to you, and age.

_____

_____

_____

Medical Information:

Do you currently have any medical issues or concerns? _____

_____

Past medical problems, hospitalizations, or surgeries_____

_____

Please list any allergies including drugs, food, or other _____

Do you currently take any prescription meds, over the counter meds, or supplements? ___Y ___N

If yes, please list name, dosage, and frequency _____

_____

_____

Substance Use:

Do you currently use or have used alcohol or other drugs? ___Y ___N

If yes, please check all substances that apply and list, amount of use, how often, how long, and last use.

[] alcohol _____

[] amphetamines/speed _____

[] barbiturates/downers_____

[] caffeine _____

[] cocaine_____

[] hallucinogens (e.g., LSD, PCP) _____

[] inhalants (e.g., glue, gas) _____

[] marijuana _____

[] nicotine/cigarettes _____

[] other_____

Prior treatment for substance use? ___Y ___N

If yes, please provide details regarding where, when, and for what substance. _____

_____

_____

Trauma History

Do you have history of trauma from childhood abuse, military, combat, workplace, domestic violence, sexual assault, or medical trauma? _____

_____
_____
_____
_____

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 Supports:

[] supportive network [] few friends [] substance-use-based friends [] no friends

[] distant from family of origin

Sexual History:

How do you identify your sexual orientation? [] heterosexual [] homosexual [] bisexual [] transsexual

[] unsure/questioning [] prefer not to answer [] other _____

Are you currently sexually active? ___Y ___N

Do you have any concerns regarding your sexuality or sexual practices? ___Y ___N

If yes, please provide more information _____

_____

Legal history:

[] no legal problems [] arrest(s) not substance-related [] court ordered to treatment

[] supervisor conflicts [] now on parole/probation [] arrest(s) substance-related [] jail/prison time(s)

What are your strengths? _____

What areas would you like to see improvement? _____