SAMARITAN COUNSELING & GROWTH CENTER
245 SE MADISON BLVD.
BARTLESVILLE, OK 74006

ADULT CLIENT INTAKE INFORMATION SHEET

Name: First_____ MI _____ Last _____ **Age:** _____ **DOB** ____/____/_____

Address: _____ **Apt. #:** _____

City: _____ **State** _____ **Zip** _____

Ethnicity: ☐ White ☐ Black ☐ Native American ☐ Asian ☐ Hispanic ☐ Other

Gender: ☐ Male ☐ Female **Social Security Number**: _____-_____-_____

Annual Household Income: ☐ **$0-$9,999** ☐ **$10,000-$14,999** ☐ **$15,000-$19,999** ☐ **$20,000-$24,999**
☐ **$25,000-$49,999** ☐ **$50,000 or more** ☐ **Confidential**

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

Preferred Method for Courtesy Appointment Reminders:

☐ Do not remind me ☐ Call to Home Phone ☐ Call to Mobile Phone ☐ Call to Work Phone

You are responsible for appointments you schedule whether you receive a courtesy call or not.

Emergency Contact: _____ **Phone:** _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Domestic Partner

Employment: ☐ Employed ☐ Unemployed ☐ Student ☐ Disabled

Occupation: _____ **Employer:** _____

Were you referred to our office? _____ **If yes, by whom?** _____

☐ Internet ☐ Phone Book ☐ Friend or relative ☐ Clergy ☐ Doctor _____

Responsible Party: (list the name of the person who is financially responsible for your account)

Individual's Name: _____**Phone:** _____

Address: _____ City _____ State _____ Zip _____

Primary Insurance Coverage:

Policy holder's Last Name_____First_____

Birth date: ____ / ____ / ____ Sex: ☐ **M** ☐ **F** Relation to client _____

Social Security # _____ - _____ - _____ Employer _____

Insurance Company_____

Policy ID # _____Group ID# _____

Current Problem: (Describe the problem/s for which you are now seeking help.)

_____

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Having read and completed the Personal History form, I hereby declare that the information I have given is correct and complete, to the best of my ability.

Signed: _____ **Date:** _____

Clinical Intake Information

Client Name: _____

How long have you been experiencing this problem?

What have you done to try to solve this problem?

How successful have your efforts been in solving the problem? ☐ Unsuccessful ☐ Successful

Have you had any prior counseling? ☐ Yes ☐ No If yes, please complete the following:

Counselor	Dates	Nature of Problem
_____	_____	_____
_____	_____	_____

Other Current Problems (please rate: 0=none, 1=mild, 2=moderate, 3=severe)

_____ marriage	_____ divorce	_____ alcohol/drug	_____ faith
_____ premarital	_____ child custody	_____ addictions	_____ religion
_____ singleness	_____ disabled	_____ grief/loss	_____ past hurts
_____ sexual issues	_____ work/career	_____ codependency	_____ depression
_____ family	_____ school	_____ fear/anxiety	_____ intimacy
_____ children	_____ money	_____ anger control	_____ mood swings
_____ parents	_____ aging	_____ communications	_____ loneliness
_____ in-laws	_____ weight	_____ stress management	_____ distrust
_____ hearing voices	_____ aches/pains	_____ seeing things	_____ self esteem

Critical Stress Information

Have you had thoughts about harming yourself? ☐ Yes ☐ No

If yes, how recently? _____ How often? _____

Have you had thoughts about harming others? ☐ Yes ☐ No

If yes, when? _____

Have you experienced any of the following:

☐ Hospitalization or incarceration for suicidal or assaultive behavior

Where Hospitalized?_____ Dates _____

Length of Stay? _____ Reason_____

☐ Homicidal or assaultive thoughts or feelings or anger control problems?

☐ Threats of significant loss or harm (illness, divorce, custody, job loss?)

Clinical Intake Information

Client Name: _____

Personal History

List name, age, sex and relationship of all children:

Name	Age	Sex	Biological or Step	Living at Home
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Marital Status (more than one answer may apply)

___ Single ___ Separated ___ Divorce in Process ___ Unmarried ___ Living together ___ Widowed ___ Annulment

___ Married # of times _____ Length of Time _____

Medical Information

Family Doctor: _____
Name Address Phone

Date of last physical: _____

Describe any medical problems or surgeries:

_____

_____

Are you presently taking any medication? ☐ Yes ☐ No

Prescription Medication	Dosage/Frequency	Reason	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Over the Counter Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____

Are you experiencing difficulties or changes in any of the following?

☐ Eating ☐ Sleeping ☐ Weight ☐ Pain ☐ Sex Drive

Sexual History (The following questions involve sensitive issues. Please answer if you feel comfortable.)

Sex was an uncomfortable or negative topic in the home in which I grew up ☐ Yes ☐ No

I have been, or suspect I have been sexually abused ☐ Yes ☐ No

Sex is unpleasant for me ☐ Yes ☐ No

Please offer any explanation that would be helpful: _____

_____

_____

Clinical Intake Information

Client Name: _____

Spiritual/Religious

How important are spiritual or religious matters to you? ☐ Not ☐ Little ☐ Some ☐ Much

Are you affiliated with a spiritual or church group? ☐ Yes ☐ No

Would you like your spiritual/religious belief incorporated into your counseling? ☐ Yes ☐ No

Are you participating in any other spiritual or recovery groups? If so, please list groups attended

_____

_____

_____

Legal

Are you involved in any active case, civil or criminal? ☐ Yes ☐ No

Are you presently on probation or parole? ☐ Yes ☐ No

Past History: DWI, DUI: ☐ Yes ☐ No

Criminal Involvement _____

Education

_____ High School/GED Graduate Last Grade Completed _____

_____ Vocational Technical: Number of years _____

_____ College: Number of years _____ Graduated ☐ Yes ☐ No Degree: _____

_____ Other Training: _____

Currently Enrolled: _____

Career of Choice: _____

Social Information

Would you say that you have several relationships you enjoy with people outside your family? ☐ Yes ☐ No

What do you do for recreation and hobbies? How much time do you spend each week?

_____

List community or other organizations (PTA, kid's sports, church groups, etc.) with which you are involved. How much time do you spend in these activities each week?

_____

Please describe your level of physical activity, how long you have participated and the frequency of your participation?

_____

_____

Clinical Intake Information

Client Name: _____

Extended Family History

Name	Relationship	Living	Describe Relationship		
_____	_____	____	☐ Good	☐ Ok	☐ Bad
_____	_____	____	☐ Good	☐ Ok	☐ Bad
_____	_____	____	☐ Good	☐ Ok	☐ Bad
_____	_____	____	☐ Good	☐ Ok	☐ Bad

What was the atmosphere in your home while you were growing up? _____

_____

If you were adopted, please describe your current relationship with your birth parents. _____

_____

Has anyone in your immediate family committed suicide? ☐ Yes ☐ No

If yes, who? _____

Having read and completed the Personal History form, I hereby declare that the information I have given is correct and complete, to the best of my ability.

Signed: _____ Date: _____

(Thank you for taking the time to fill out the Personal History Information Sheet. Your counselor will use it to best assist you in our counseling work. We will maintain your strict confidence regarding this information, subject to the exceptions noted in the Client Information and Consent for Counseling Form.)