

CONFIDENTIAL CLIENT QUESTIONNAIRE

(Please print)

Date: ____/____/____

Office use only:

Initials _____

Type _____ Location _____

Code _____

CLIENT INFORMATION

Name _____ Soc. Sec. # _____

Last Name

First Name

Initial

Address _____

Street

City

State

Zip

Home Phone _____ Cell Phone _____ Religion _____

Sex: M F Age _____ Birthdate ____/____/____ Single Married Widowed Separated Divorced

Client Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Street

City

State

Zip

Who referred you to the Samaritan Center?

BILLING/PRIMARY INSURANCE INFORMATION

If client is covered by insurance please answer the following:

Subscriber's Full Name _____ Relation to Client _____ Birthdate ____/____/____

Home

Address (if different from client) _____ Phone _____

Street

City

State

Zip

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Phone No. _____

Soc. Sec. # _____ Group # _____ Policy # _____

If client is not covered by insurance, please complete billing information below:

Person Responsible for Account _____

Last Name

First Name

Initial

Relation to Client _____ Birthdate: ____/____/____ Soc. Sec. #: _____

Address (if different from client) _____ Home Phone _____

Street

City

State

Zip

Person Responsible Employed by _____ Occupation _____

SECONDARY INSURANCE

Subscriber's Full Name _____ Relation to Client _____ Birthdate ____/____/____

Home

Address (if different from client) _____ Phone _____

Street

City

State

Zip

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Phone No. _____

Soc. Sec. # _____ Group # _____ Policy # _____

ASSIGNMENT AND RELEASE

I, the undersigned, understand that I am solely responsible for all payments when services are rendered. **-OR-**
I, the undersigned, have insurance coverage with the above-mentioned insurance company, and assign directly to the SAMARITAN COUNSELING CENTER all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize SAMARITAN COUNSELING CENTER to release any medical or relevant information acquired in the course of my treatment to process insurance claims necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Continued on Back

Date

I. Current Living Situation: Fill in your full name, check (3) gender and list age. Complete same information for all other persons living at your address.

First Name	Last Name	Check (3)		Age	Relationship
		Male	Female		(Spouse, daughter/son, mother/father, sister/brother, grandparent, step-, etc.)
					Self

Please check any of the following, which may apply:

Family Concerns

- Conflict
- Communication
- Custody/Visitation
- Loss
- Abusive Behavior
- Disability
- Suicidal Thoughts/Talk/Behavior
- Other _____
- Parenting
- Step-Family
- Finance
- Addiction
- Anger
- Gender Issues

Child/Teen Concerns

- Arguing/Fighting
- Sadness
- School Problems
- Peer Problems
- Legal Problems
- Drugs/Alcohol
- Suicidal Thoughts/Talk/Behavior
- Other _____
- Temper Tantrums
- Withdrawn
- Learning Disability
- Lying
- Dangerous Behavior
- Sexual Problems

Recent Adjustments: Divorce Remarriage Move Birth Death Job Change
 Health Problems Empty Nest Retirement Other: _____

II. Relationship Status

- Single Serious Relationship Engaged Married Separated Divorced Widowed

Date of Current Marriage: ___/___/___ # Children: _____

Relational Satisfaction: Very Happy Satisfied Somewhat Dissatisfied Very Unhappy

Previous Marriages:

Year Married: _____ Year Divorced: _____ # Children: _____
 Year Married: _____ Year Divorced: _____ # Children: _____
 Year Married: _____ Year Divorced: _____ # Children: _____

Relationship Concerns

Please check any of the following, which may apply:

- Communication
- Expectations
- Loss of Love
- Domestic Roles
- Conflict
- Jealousy
- Abuse
- Addiction
- Finances
- Careers
- Intimacy
- Religion
- Relatives
- Infidelity
- Trust
- Illness
- Sexual Difficulties
- Decision Making
- Controlling Behaviors
- Time Spent Together

III. Family of Origin History

Mother: _____ Living Age: ____ Deceased Year ____

Father: _____ Living Age: ____ Deceased Year: ____

Please list siblings from **oldest to youngest**. Please place yourself on the list.

Sibling	M/F	Age	Notes	Sibling	M/F	Age	Notes

How would you describe your parents' marriage?

- Very Happy Happy Neutral Feeling Unhappy Very Unhappy

From birth to 18, were you mostly raised by:

- Natural/Adoptive Parents Single Parent Natural Parent and Step Parent Other Guardian(s)

Is there a family history of any of the following:

- Depression Mood Swings Abuse Addiction Mental Illness Suicide

IV. Personal Information

Highest Education: _____ Did you serve in the military? Yes No

Check any of the following that apply to your childhood or adolescence:

- Happy childhood Emotional Problems School Problems Behavior Problems
 Abuse Family Problems Medical Problems Drug/Alcohol Abuse

List current health problems: _____

List current medications: _____ Dosage: _____

Name of Physician: _____ Phone #: (____) _____ - _____

Have you sought counseling before? Yes No

Name of Therapist(s): _____

Have you ever been hospitalized for a psychiatric problem?

Have you ever made a suicide attempt? Yes No

Please describe the main concern which brings you to counseling:

Please check any of the following which may apply to you:

- Depressed Mood Grief/Loss Panic Attacks Excessive Worry
 Lost Interest in Activities Guilty Feelings Fears Poor Concentration
 Negative Outlook Eating Problems Hyperactive Physical Complaints
 Feeling Worthless Sleep Problems Mood Swings Thoughts of Suicide
 Fatigue Anxiety Compulsive Actions Obsessive Thoughts

V. FAITH BACKGROUND

It is the philosophy of the Samaritan Counseling Center to work within the faith framework of the client. Staff Therapists do not impose personal beliefs upon clients.

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

City

State

How many years have you attended? 0–2 years 3–5 6–10 Over 10

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

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

Please check any faith/spiritual concerns that may apply to you:

- | | | |
|--|---|--|
| <input type="checkbox"/> Spiritual Hunger | <input type="checkbox"/> Loss of Faith | <input type="checkbox"/> Faith Differences with Partner/Family |
| <input type="checkbox"/> Moral Dilemma | <input type="checkbox"/> Guilt Feelings | <input type="checkbox"/> Inability to feel Forgiveness |
| <input type="checkbox"/> Unable to Forgive | <input type="checkbox"/> Religious Doubts | <input type="checkbox"/> Confusion about Values |
| <input type="checkbox"/> Anger at God | <input type="checkbox"/> Hurt by Faith | <input type="checkbox"/> Painful Religious History |

Other

Do you actively participate in and/or receive spiritual support from:

- | | |
|--|---|
| <input type="checkbox"/> Personal Prayer | <input type="checkbox"/> Congregation Support |
| <input type="checkbox"/> Spiritual or Bible Readings | <input type="checkbox"/> Support of Clergy |
| <input type="checkbox"/> Spiritual Direction | <input type="checkbox"/> Bible Study |
| <input type="checkbox"/> Spiritual Disciplines | <input type="checkbox"/> Small Groups at church |

At your request, our Staff Therapists can include faith, values and spiritual concerns in the counseling process. Please check any of the items below which you would like your counselor to provide for you:

- | | |
|---|--|
| <input type="checkbox"/> Pray together at the close of sessions | <input type="checkbox"/> Discuss insights of faith in relation to current problems |
| <input type="checkbox"/> Use Biblical and/or faith examples | <input type="checkbox"/> Recommend religious and/or spiritual readings |
| <input type="checkbox"/> Recommend spiritual growth activities | <input type="checkbox"/> Share personal faith perspectives when appropriate |

Please take a moment to read the Samaritan Counseling Center Information Sheet!