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? ______________________________________
Email Address: ______________________________________

BILLING/PRIMARY INSURANCE INFORMATION

If client is covered by insurance please answer the following:

Subscriber's Full Name ______________________________ Relation to Client ____________ Birthdate _____/_____/_____

Address (if different from client) ____ Home 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 _____/_____/_____

Address (if different from client) ____Home 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) Male	Female	Age	Relationship (Spouse, daughter/son, mother/father, sister/brother, grandparent, step-, etc.)
					Self

Please check any of the following, which may apply:

Family Concerns

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

Child/Teen Concerns

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- ❑ Withdrawn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

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

❑ Spiritual Hunger ❑ Loss of Faith ❑ Faith Differences with Partner/Family

❑ Moral Dilemma ❑ Guilt Feelings ❑ Inability to feel Forgiveness

❑ Unable to Forgive ❑ Religious Doubts ❑ Confusion about Values

❑ Anger at God ❑ Hurt by Faith ❑ Painful Religious History

Other ____

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

❑ Personal Prayer ❑ Congregation Support

❑ Spiritual or Bible Readings ❑ Support of Clergy

❑ Spiritual Direction ❑ Bible Study

❑ Spiritual Disciplines ❑ 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:

❑ Pray together at the close of sessions ❑ Discuss insights of faith in relation to current problems

❑ Use Biblical and/or faith examples ❑ Recommend religious and/or spiritual readings

❑ Recommend spiritual growth activities ❑ Share personal faith perspectives when appropriate

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

I understand the following about my therapy at the Samaritan Counseling Center:

Therapy is intended to help me personally and with relationships. **Discussing psychological, emotional and/or relationship issues may be distressing at times.**

- I may leave therapy at any time though the decision is best made together with my therapist.
- SCC is not an emergency service. Thus, if I am unable to reach my therapist promptly, I have been advised to contact my local emergency facilities.
- SCC will not release any information about me including my name without a written consent form except in dangerous situations or by court subpoena.
- The goals and progress in therapy will be reviewed on a regular basis. These reviews are intended to confirm ongoing consent for treatment.
- SCC does not offer medical, legal and psychiatric services including the dispensing of drugs and medications. Your therapist is able, however, to make an appropriate referral for you to these services.
- The client is responsible for fees of therapy in the event that insurance unexpectedly denies payment.
- The client is responsible for any fees incurred through the collection of any remaining balance on your account.
- I understand the Notice of Privacy Practices including my client rights.
- I have received a copy of the Notice.
- Samaritan Counseling Center is a faith-based counseling center. It is our philosophy to work within the belief system of the client. The Center's therapists do not impose their personal beliefs upon clients; and include discussion of spirituality /religion/faith according to the expressed preference of the client.

Each person participating in counseling should sign below.

______________________	__________	______________________	__________
Client Signature	Date	Client Signature	Date
______________________	__________	______________________	__________
Client Signature	Date	Client Signature	Date

________________________ ____________

Staff Therapist Date