

INTAKE INFORMATION FORM – ADULT

(PLEASE PRINT)

Appointment Date and Time:	For Therapist Use Only:
Appointment Date: ____ / ____ / ____	Diagnosis: _____
Time: _____	IP: _____
Therapist: _____	Type Code: <input type="checkbox"/> I <input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> E
Office: _____	Payment Type: <input type="checkbox"/> Insurance <input type="checkbox"/> Private Pay

Important: Each person going into the session should complete an intake form for him- or herself. Parents ***should not*** complete the form in their child’s name. Couples should use ***two*** intake forms.

Name: _____ Date of Birth: _____ SS#: _____ Gender: M / F

Address: _____ City, State, ZIP: _____

Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

Would you like to receive our quarterly Solutions newsletter, workshop announcements and other information? Yes, by Mail Yes, by Email No, Thank you

Spiritual Concerns:

How important is spiritual commitment to you?
 Unimportant Below average Average Above Average Very Important

Do you desire having your spiritual beliefs and values incorporated into the therapy process?
 No Yes Not Sure

Church / Congregation _____
Worship Leader’s Name _____

Age:	Marital Status:	Referral Source:	Religious Affiliation:
<input type="checkbox"/> Birth – 4	<input type="checkbox"/> Single	<input type="checkbox"/> Self	<input type="checkbox"/> Catholic
<input type="checkbox"/> 5 – 9	<input type="checkbox"/> Living w/ Partner	<input type="checkbox"/> Family / Friend	<input type="checkbox"/> Lutheran
<input type="checkbox"/> 10 – 15	<input type="checkbox"/> Married	<input type="checkbox"/> Former Client	<input type="checkbox"/> Unitarian
<input type="checkbox"/> 16 – 19	<input type="checkbox"/> Separated	<input type="checkbox"/> Clergy	<input type="checkbox"/> Episcopalian
<input type="checkbox"/> 20 – 30	<input type="checkbox"/> Divorced	<input type="checkbox"/> School	<input type="checkbox"/> Methodist
<input type="checkbox"/> 31 – 40	<input type="checkbox"/> Widowed	<input type="checkbox"/> Social Agency	<input type="checkbox"/> Baptist
<input type="checkbox"/> 41 – 50		<input type="checkbox"/> EAP or Insurance	<input type="checkbox"/> Reformed
<input type="checkbox"/> 51 – 60		<input type="checkbox"/> Physician	<input type="checkbox"/> Pentecostal
<input type="checkbox"/> 61 – 70		<input type="checkbox"/> Other Therapist	<input type="checkbox"/> Presbyterian
<input type="checkbox"/> 71 – 80		<input type="checkbox"/> Legal System	<input type="checkbox"/> Community Church
<input type="checkbox"/> 81 +		<input type="checkbox"/> Other	<input type="checkbox"/> Jewish
			<input type="checkbox"/> Other
			<input type="checkbox"/> None

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Please fill in the box below with your insurance authorization information. If you do not have an authorization number, ask your therapist about the procedure for getting one.

Authorization Information	
Authorization Number	
Authorization Start Date	End Date
Number of Sessions	
Is this an EAP / Employee Assistance Plan?	Yes No

If you receive(d) a letter from your Insurance Company or EAP, please provide a copy.

Have you been given the opportunity to review our Privacy Practices? No Yes

Please read and sign below:

I request payment of authorized benefits to me or on my behalf for any service furnished me by Samaritan Counseling Center, including physician services. I authorize the release of information necessary to process this claim through an insurance review including any periodic treatment review with the Managed Care Company. I also authorize Samaritan Counseling Center to consult with my physician and / or referring professional. I agree to pay charges not covered by my insurance.

Signature: _____

Who is the primary person on the insurance plan? _____

Insured Person's Place of Employment: _____

Address if different from yours:

Address: _____ City, State, ZIP: _____

Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

Insurance Information:

Insurance Company: _____
Plan Name: _____
ID# / Member #: _____
Policy # / Group #: _____

Secondary Insurance: _____
Plan Name: _____
ID# / Member #: _____
Policy # / Group #: _____

Please give us a copy of your insurance card!

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Employment Status:

- Employed Full Time Employed Part Time Full Time Student Part Time Student
 Unemployed Homemaker Volunteer

School You Attend: _____ Highest Level of Education Completed: _____

Place of Employment: _____

Children and / or Siblings:

Name: _____ Date of Birth: _____

Emergency Contact Information:

Name: _____ Phone: _____
Relationship: _____

Medical Information:

Primary Care Physician: _____
Address: _____
Phone: _____

Allergies: _____
Medications Taken: _____

Have you ever been hospitalized or had a major illness? _____
When / For What? _____

Do you drink alcohol? No Yes How many times per week? _____
Do you smoke cigarettes? No Yes How many times per day? _____

Office Survey:

Was the office location convenient? Yes No
Was the waiting room comfortable? Yes No
When you first called Samaritan, were you treated courteously and professionally? Yes No
Were scheduling procedures and insurance or payment information explained? Yes No
Did someone return your call within 24 hours to schedule an appointment? Yes No

Comments:

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Pre-Session Evaluation:

What is the primary concern that you would like to address in therapy?

How has this affected your ... (1 = Not at all, 5 = Very Much)

Marriage / Partner	1	2	3	4	5
Family	1	2	3	4	5
Job / School Performance	1	2	3	4	5
Friendships	1	2	3	4	5
Finances	1	2	3	4	5
Health	1	2	3	4	5
Anxiety Level	1	2	3	4	5
Mood	1	2	3	4	5
Sexuality	1	2	3	4	5
Eating Habits	1	2	3	4	5
Sleep	1	2	3	4	5
Concentration	1	2	3	4	5
Parenting	1	2	3	4	5
Anger	1	2	3	4	5

Is there now or has there been any substance abuse in your family? No Yes

Relationship: _____

Do you have concerns about abuse? No Yes

- Physical
- Sexual
- Emotional
- Substance

Do you ever think of committing suicide? No Yes

Have you ever attempted suicide? No Yes

Do you presently have suicidal thoughts? No Yes

When? _____

Has anyone in your family been seen by a therapist at Samaritan Counseling Center?

Yes When? _____ Therapist: _____

Have you had previous therapy (here or elsewhere)?

Yes When? _____ Reason: _____

SAMARITAN COUNSELING CENTER OF THE CAPITAL REGION

Help and Hope for your Mind and Spirit