

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 his/her OWN intake form. Parents ***should not*** complete the form for their child. Couples should use ***two*** intake forms.

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

Address: _____

City, State, ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Would you like to receive our quarterly Solutions newsletter, workshop announcements and other information? Paper mail E-mail 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 (location/name) _____
 Worship Leader's Name _____

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

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Please fill in the box below with your insurance mental health benefit 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? Yes No

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? _____

Place of Employment providing the insurance: _____

Insured Person's Address, *if different* from yours:

Address: _____ City, State, ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Insurance Information:

Insurance Company: _____

Secondary Insurance: _____

Plan Name: _____

Plan Name: _____

ID# / Member #: _____

ID# / Member #: _____

Policy # / Group #: _____

Policy # / Group #: _____

SAMARITAN COUNSELING CENTER OF THE CAPITAL REGION

Help and Hope for your Mind and Spirit

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Employment Status:

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

Place of Employment: _____

Highest Level of Education Completed: _____

If Student, school you presently attend: _____

Children (or siblings, if you are under 21):

| | |
|-------------|----------------------|
| Name: _____ | Date of Birth: _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Emergency Contact Information:

Name: _____ Relationship: _____
Phone: _____

Medical Information:

Primary Care Physician: _____
Address or Location: _____
Phone (if known): _____
Allergies (other than seasonal): _____
Medications Taken: _____

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

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

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? Yes No

Relationship: _____ Would you like Al-Anon information? Yes No

Do you have concerns about abuse? Yes No

- Physical Emotional
- Sexual Substance

Have you ever hurt yourself on purpose? Yes No

Do you ever think of committing suicide? Yes No

Have you ever attempted suicide? Yes No When? _____

Do you presently have suicidal thoughts? Yes No

Has anyone in your family been seen by a therapist at Samaritan Counseling Center? No

Yes When? _____ Therapist: _____

Have you had previous therapy (here or elsewhere)? No

Yes When? _____ Reason: _____

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