

**SAMARITAN COUNSELING CENTER OF THE NORTHWEST SUBURBS
CLIENT INTAKE INFORMATION FORM**

The information requested in this form will be kept confidential, and will help your counselor to assist you. Please fill out the form as completely as you can. Write in words or numbers where asked.

GENERAL INFORMATION

Last Name _____ First Name _____ Middle Initial ____

Guardian/parent (if under 18) _____

Referred by: _____

Reason for Referral _____

Reason for choosing this Center _____

Religious/denominational preference _____

Your congregation/church/temple (if applicable) _____

EMPLOYMENT/EDUCATION INFORMATION

Full time employee Part-time employee Unemployed Student Child or Adolescent

Place of employment _____ Length of Employment _____ Years

Type of work you do _____

Highest Level of Education (Adults Only): High School College degree Graduate degree

Professional training Other _____

Current Grade (Children and Adolescents Only) _____

FAMILY INFORMATION

Relationship Status (Adults Only): Single Engaged Married Separated Divorced

Widow(er) Living with a Partner

Parents: *Mother*: living, age _____ Deceased. *Father*: living, age _____ Deceased

Siblings: Number of Brothers []. Number of Sisters []. Only Child

List ages of Brothers [] of Sisters [].

Names and ages of your Children (if applicable): _____

_____ Have any of your children died? _____

Spouse's/Partner's name (if applicable): _____

Emergency Contact: Name/Phone/Relationship to you. _____

Do you feel Safe at Home? Yes No Explain: _____

MEDICAL/PSYCHOLOGICAL HISTORY

Date of last physical: _____

Are you suffering any physical illnesses or symptoms at this time? _____

List major surgeries or illnesses in the last five years: _____

List current medication and dosage instructions: _____

Have you or any member of your family received help for drug or alcohol dependency? Yes No

When? _____ Name of helping agency _____

Are you concerned about any family members alcohol/drug usage? Yes No

Has anyone ever been concerned about your alcohol/drug usage? Yes No

Have you received psychotherapy or counseling in the past? Yes No. When? _____

Name of treating therapist: _____

Have you ever been on any psychiatric medicine? Yes No (continued on page 2...)

Type & Dose _____

PROBLEM DEFINITION

What is your reason for seeking help now? _____

Are any of the following conditions a problem to you or your child if (s)he is the client at this time?
(Check the ones that apply)

- Anxiety
- Grief
- Depression
- Irrational Fears
- Guilt feelings
- Stress
- Frequent worry
- Loneliness
- Anger
- Loss of work/job
- Poor Concentration
- Racing Thoughts
- Difficulty Sleeping
- Nightmares
- Loss of interest in life
- Codependency
- Flashbacks
- Too much energy
- Feels of lethargy
- Loss of appetite

- Self Esteem
- Substance use/abuse (self)
- Substance use/abuse (others)
- Suicidal feelings
- Loss of hope
- Rage
- Marriage problems
- Sexual problems
- Relationship to parents
- Relationship to adult children
- Parenting Issues
- Coping with a divorce
- Mood instability
- Domestic violence
- Sexual, physical, emotional abuse (present or past)
- Sexual identity crisis
- Self Injury behaviors
- Issues with eating
- School problems

- Work problems
- Financial Stress
- Loss of meaning in life
- Loss of faith in God
- Conflicts at work
- Hyperactivity
- Impulse control problems
- Stress due to Caretaking
- Other (List)
- _____
- _____
- _____
- _____
- _____
- _____

What would you like to see happen as a result of psychotherapy or counseling?

Make a check mark if any of these statements are true:

- I have had thoughts of harming myself or someone else
- My thoughts of harming myself or someone else are frequent
- I am sometimes afraid I cannot control my thoughts of hurting myself or someone else
- I have sought help in the past due to thoughts of hurting myself or others

ACKNOWLEDGEMENT Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

CLIENT'S SIGNATURE (12 and over)

DATE

PARENT OR GUARDIAN SIGNATURE

DATE