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
___Partner Relationship 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

BILLING AND INSURANCE VERIFICATION RELEASE FORM

Samaritan Counseling Center of the NW Suburbs
800 N Hart Road, Suite #250
Barrington, IL 60010

Counselor use: COUNSELOR: __________ GAF:______
Amount Charged: $__________
DX Code: ____________ FF _______ INS _______FS $_______

Thank you for choosing Samaritan Counseling Center. By answering the questions below as completely as you can, you will help us to understand you and your situation more fully. **ALL INFORMATION IS CONFIDENTIAL.**

Client's Name: First MI Last			Gender: ☐ Male ☐ Female	Today's Date / /
Address:		City	State	Zip
Home Phone # ( )	Work Phone: # ( )		Cell Phone # ( )	
Spouse/Parent/Other Phone # ( )		Email Address:		
Employer:		Social Security Number: ________-____-________		
Date of Birth: ____/____/_____ Age: __________	Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Child/Adolescent ☐		Ethnic Background: African American ☐ Asian American ☐ Caucasian ☐ Hispanic ☐ Other:_______________	

Please list all the members of your household (List any additional phone numbers on the back of form):

Name	Age	Date of Birth	Gender	Occupation/Employer	Religion

Which of the following categories best describes your household's total income before taxes last year? Please include from all sources such as salaries and wages, Social Security, retirement income, investments, and other sources.	☐ Less than $20,000	☐ $20,000 - $39,999
	☐ $40,000 - $59,000	☐ $60,000 - $79,999
	☐ $80,000 - $99,999	☐ $100,000 or more

WHO IS RESPONSIBLE FOR THIS ACCOUNT? Name(s): ____

Address/Phone (if different from client name above): ____

Social Security Number (if different from number provided above): ______________-_____________-_____________

WILL YOU BE USING INSURANCE? ☐ Yes ☐ No IF YES, PLEASE PROVIDE YOUR INSURANCE CARD

Social Security Number of Primary Insured (if different from number provided above): _________-_______-_________

Birthdate of Primary Insured (if not listed above):____/____/_____

PATIENT'S OR AUTHORIZED PERSONS SIGNATURE -

- I authorize the release of any medical or other information necessary to process this claim.
- I authorize payment of medical benefits to Samaritan Counseling Center for services rendered.
- **I ACCEPT THE FINANCIAL RESPONSIBILITY OF ANY BALANCE REMAINING ON ACCOUNT AFTER INSURANCE HAS PROCESSED THE CLAIM**

PLEASE SIGN ____ **DATE** ____________________________

CANCELLATION & RETURN CHECK POLICIES

- Because counseling hours are reserved, Samaritan Counseling Center charges $100 for canceled sessions when less than 24 hours notice is given.
- There will be a $25.00 service charge on all returned checks.

I understand the policies as stated above. **Signature**_____________________________ **Date**___________________

SAMARITAN COUNSELING CENTER OF THE NORTHWEST SUBURBS

NOTIFICATION TO CLIENT OF DESIRABILITY OF CONFERING WITH PRIMARY CARE PHYSICIAN

If you have a primary care physician we would welcome the opportunity to notify him or her that you are seeking or receiving mental health treatment unless you waive such notification.

PLEASE INDICATE YOUR WISHES

PRIMARY PHYSICIAN:____

ADDRESS:____

____

PHONE: ______________________

FAX:_________________________

❑ I agree to your notifying my Primary Care Physician that I am seeking or receiving mental health services. I am signing this authorization permitting you to communicate with my said physician.

❑ I waive notification of my Primary Care Physician that I am seeking or receiving mental health services, and I direct you not to notify him/her.

❑ I do not have a Primary Care Physician and do not wish to see or confer with one. I therefore, waive notification of a Primary Care Physician that I am seeking or receiving mental health services.

Signature: ____________________________________ Date: ________________
(12 and over)

Signature:_____________________________________Date: ________________
(Parent or Guardian)

SAMARITAN COUNSELING CENTER OF THE NORTHWEST SUBURBS

TELEPHONE CONTACT PERMISSION FORM

NAME: ____ (PLEASE PRINT)

Occasionally, we may find that we need to contact you regarding your appointment or your account. In an effort to protect your privacy, please fill out the following questionnaire on what would be the best way to contact you personally.

MAY WE CONTACT YOU REGARDING YOUR APPOINTMENTS OR YOUR ACCOUNT?

YES ❑ NO ❑

WHAT NUMBER DO YOU PREFER TO BE CONTACTED AT?

HOME Home phone number: ____________________

CELL Cell phone number: ____________________

WORK Work phone number: ____________________

IF YOU ARE UNAVAILABLE, MAY WE LEAVE A MESSAGE ON YOUR VOICEMAIL OR ANSWERING MACHINE?

HOME ❑

CELL ❑

WORK ❑

IF YOU ARE NOT HOME, MAY WE LEAVE THE MESSAGE WITH SOMEONE AT YOUR RESIDENCE?

YES ❑ NO ❑

PERSON TO CONTACT IN THE EVENT OF AN EMERGENCY:

NAME:________________ PHONE:____________ RELATIONSHIP:__________

If we do not have this form on file, we will NOT call you to remind you of your appointments or any matters regarding your account. You will be notified by mail if the need arises.

SIGNATURE: ______________________________ DATE:______________