

**CLIENT INFORMATION**  
For Confidential Use Only

Chart # \_\_\_\_\_

Legal Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_  
Street Address \_\_\_\_\_ Apartment # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Leave Message?  Yes  No      Leave Message?  Yes  No      Leave Message?  Yes  No

E-Mail Address \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
Name and phone number \_\_\_\_\_

Occupation \_\_\_\_\_ Employer/School \_\_\_\_\_

Number of years (or highest level of) education \_\_\_\_\_

Gender \_\_\_\_\_ Relationship (or Couple) Status \_\_\_\_\_ Race/Ethnicity \_\_\_\_\_

Name/Address of financially responsible party if other than client *(For minors or anyone using 3<sup>rd</sup> party, non-insurance payor.)*

If client is a minor, name/address/phone of custodial parent, if different from name above \_\_\_\_\_

Gross annual family income \$ \_\_\_\_\_ per year      Number dependent on this income \_\_\_\_\_

Family and household members (includes housemates, spouse, partner and all children *(Continue on back if needed.)*)  
Clarify if client is a minor from two households *(Include any different last names.)*

Name	Age	Gender	Relationship	Living with you?	
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Religion \_\_\_\_\_ Place of worship \_\_\_\_\_

Is it important for you to have spirituality included in your therapy?  Yes  No

PLEASE CONTINUE ON PAGE 2 ↪

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_ Date of last exam \_\_\_\_\_

Physician's Address \_\_\_\_\_

It is our practice to coordinate care with the client's physician when this would be helpful. If you agree that we may contact your physician, please check here:  (Please sign a release of information with your therapist for this purpose.)

List any surgeries or illnesses you have had the past five years \_\_\_\_\_

List any medications, including the amount, that you currently take or have taken in the past 3 months \_\_\_\_\_

What is your purpose in coming to Samaritan at this time? \_\_\_\_\_

Have you done previous counseling/therapy?  Yes  No If yes, when? \_\_\_\_\_

Name of Previous Therapist(s) \_\_\_\_\_ Purpose/issues at that time \_\_\_\_\_

Are you a returning client?  Yes  No How did you learn about Samaritan? \_\_\_\_\_

Did you come because you had a specific therapist in mind?  Yes  No Name of therapist \_\_\_\_\_

Did you come because our therapist was on your insurance provider list?  Yes  No

Did someone refer you to Samaritan?  Yes  No Name of person referring: \_\_\_\_\_

Relationship to you \_\_\_\_\_ May we send a thank-you?  Yes  No (If yes, please give us their contact information.) First Name \_\_\_\_\_ Last Name: \_\_\_\_\_ Address (at least city & state): \_\_\_\_\_

Do you want to be added to our mailing list for e-newsletters and/or print newsletters?  Yes  No

**FOR THERAPIST'S USE**

**Therapist:** \_\_\_\_\_ **Office:** \_\_\_\_\_ **Fee (90791):** \_\_\_\_\_ **Fee (90834/47):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Payment:**  Ins\*  Samaritan Fund (requires therapist's application)  EAP  3<sup>rd</sup> Party Non-insurance Guarantor (i.e., church)  Self-pay

\* Insurance Information form must be completed, double-signed by client, stapled to photocopy of medical card, included with intake paperwork.  
 Check if insurance paperwork and/or photocopy of medical card is not included and will be submitted later.

**File:**  Individual  Couple  Family (Number of family members \_\_\_\_\_)  Group

If Couple or Family, check one:  **Primary client** ('patient' for insurance purposes; contact for scheduling)  **Additional client(s)**