

Client Legal Name _____ Today's Date _____

Address _____
Street name and number City, State, Zip Code E-Mail Address

Birthdate _____ Occupation _____ Employer/School _____

Home Phone _____ Work Phone _____ Cell Phone _____
Leave Message? ___Yes ___No Leave Message? ___Yes ___No Leave Message? ___Yes ___No

Name/Address of Financially Responsible Party (for minors or anyone using 3rd party, non-ins. payor) _____

If Client Is a Minor: Name/Address/Phone of custodial parent, if different from name above: _____

Emergency Contact _____
Name and phone number

CURRENT COUPLE STATUS

RELIGIOUS PREFERENCE

RACE/ETHNICITY

- Single Date(s): _____
- Engaged _____
- Married _____
- Prev. Marr.(s) # _____
- Partnered/cohabiting _____
- Separated _____
- Divorced _____
- Widowed _____

- Christian
- Presbyterian
- Other Protestant
- Roman Catholic
- Jewish
- Muslim
- Buddhist
- Other _____
- Not Affiliated

- African American
- Asian American
- European American
- Latin American
- Native American
- Other _____

GENDER

- Female
- Male

Name of church or place of worship: _____ # Years Education _____

Check if spirituality is important for you to have addressed or included in your therapy.

Gross Annual Family Income: \$ _____ /year Number Dependent on Income: _____

Family and Household Members (includes housemates, spouse, partner, children; continue on back if needed). Clarify if client is a minor from two households (include any different last names).

Name	Age	Sex	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

Physician's Name _____ Phone _____ Date of last exam _____

Physician's Address _____

It is our practice to coordinate care with one'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 form for this purpose.)

List any surgeries or illnesses you have had the past five years: (Continue on back if needed.) _____

List any medications with the amount you are currently taking, or have taken in the past 3 months:(Continue on back if needed.)

PLEASE CONTINUE ON REVERSE....

Have you had previous counseling/therapy? Yes No
If yes, when? _____ Name of Therapist(s) _____
Reason/issue? _____

Please state your purpose in coming to Samaritan. (*Continue below if needed.*) _____

Name and address of person who referred you to Samaritan _____
Relationship to you: _____

May we send a Thank You? (If yes, please initial.) _____ Please add me to the Samaritan mailing list. Yes No

FOR THERAPIST USE ONLY

Therapist: _____ **Branch:** _____ **Initial Session Code:** _____ **90801 Fee:** _____ **90806/47 Fee:** _____ **Date:** _____

Referral Source: Return Direct Desk

Payment: Ins* Wom/Men/Yth (requires application from therapist) EAP 3rd 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 and turned in with Intake packet
 Check if insurance paperwork and/or photocopy of medical card is forthcoming

File: Ind Cpl/Fam >> if Cpl/Fam, check one: **Primary client** ('patient' for insurance; contact for scheduling) **Additional client**

Case #: _____