



The Samaritan Center
AT THE JERSEY SHORE

Client Intake Form

Date: _____

The information requested in this form will be kept confidential and will be used to assist you.

General Information

Last Name _____ First Name _____ Middle Initial _____

Birth Date ___/___/___ Male___ Female___

Street Address _____

City _____ State _____ Zip _____

Home Telephone # _____ Cell Phone # _____

OK to leave message on: Home: Y N Cell: Y N

EMERGENCY CONTACT: Name _____ Phone # _____

Guardian/ Parent (if under 18) _____

Relationship: _____

Referred by: _____

WHAT BROUGHT you to us today? (In your own words) _____

Payment Method

Responsible Party if other than client: _____

Do you plan to file insurance for these services? Yes___ No___

Insurance Company: _____

Policy Number: _____

Policy Holders Number: _____ Date of Birth: _____

Do you wish to apply for Fee Assistance? Y___ N___

Problem Definition Please Circle All That Apply

Are any of the following conditions a problem to you at this time?

- | | | |
|----------------------------|---------------------------|-------------------|
| Anxiety | Grief | Stress |
| Depression | Alcohol/Drug Use | Conflicts at work |
| Suicidal Feelings | Hopelessness | Other (List) |
| Nervousness | Loneliness | * _____ |
| Anger | Marital Problems | |
| Job Loss | Relationship with parents | |
| Relationship with children | | |

List of current medications: _____

How do you express your spirituality? _____

Do you wish to incorporate spirituality into your therapy? Yes _____ No _____

Have you or any member of your family received Drug and Alcohol Counseling?

Yes _____ No _____

When? _____ Where? _____

Have you or any member of your family received Mental Health counseling in the past? Yes _____ No _____

When? _____ Where? _____

ADULTS:

Female: In the past three months did you have four (4) or more standard drinks per occasion? YES NO

Male: In the past three months did you have five (5) or more standard drinks per occasion? YES NO

In the last year have you used drugs other than those prescribed by a physician? YES NO

ADOLESCENTS:

Have you ever gotten into trouble while you were using alcohol or drugs?

YES NO

Have you been in a car driven by someone (including yourself) that was “high” or had been using alcohol or drugs?

YES NO

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

I give my permission to share information regarding my treatment with:

I give my permission to share billing information with:

Please note there is a \$ 40.00 cancellation fee for less than 24 hour notification.

Client or Guardian Signature _____ Date _____