Samaritan Counseling Center

Intake Form for New and Returning Clients Date: _____

We see children under 18, adults, and couples. If the client is under age 18, please tell us who their Parent or Guardian is. We also need the names of both people seeking Couples work

Name of Client	**Client's Parent** /Guardian or **Partner** (couple)
Date of Birth: _____	Date of Birth:_____
___ Female ___ Male ___ Non-binary	___ Female ___ Male ___ Non-binary
Address _____	Address _____
_____	_____
Email _____	Email _____
Phone: _____	Phone: _____
Ok to leave a message here? Yes / no	Ok to leave a message here? Yes / no
Emergency Contact: _____	Emergency Contact: _____
Would you like appointment reminders?	Would you like appointment reminders?
Yes / No: _____ by phone call, _____ text	Yes / No: _____ by phone call, _____ text
Have you seen one of our therapists before, or been seen at Samaritan in the past?	Have you ever seen one of our therapists before, or been seen at Samaritan in the past?
Yes / no Therapist Name _____	Yes / no Therapist Name _____

Marital status of Client: Single, Married, Divorced, Separated, Partnered, Widowed

Name of Insurance Plan / Company _____

ID # (with any prefixes): _____

Policy Holder Name: _____ Date of Birth_____ Male_____ Female _____

Insurance Holder's Relationship to client: ____ Self, ____ Spouse, ____ Parent, ____ Guardian, ____ Other ____

Please list any Secondary Insurance Plan: _____

Briefly describe what you hope to accomplish through counseling? _____

_____

_____

Samaritan Counseling Center

The following questions help us better know if we may be able to meet your specific needs, and what therapist may be the best fit for you. We may be able to get you an appointment within the month. Other times, you might need to wait awhile for an appointment to open up.

- Are you seeking help to get Disability, Financial Assistance, or for a Legal Case? _____ Yes _____ No
- Are you seeking help because the Court is involved or Child Protective Services? _____ Yes _____ No

- Do you come from a history of physical, sexual, or emotional abuse or neglect? _____ Yes _____ No
- Have you been to CPEP, Inpatient Psychiatric Care, or Rehab in the last 6 months? _____ Yes _____ No

Please circle all the concerns below that relate to you:

Sadness Grief / loss Lack of Motivation Suicidal thoughts / feelings /attempt
Guilt Depression Troubled dreams Child behavior problems
Anxiety Self-doubt Loss of self-respect Thoughts of hurting others
Guilt Shutting-down Domestic Violence Religious doubts / concerns
Fear Nervousness Self-harming Relationship with Parents
Anger Gender Issues Problems with food Relationship with Children
Illness Sexual Issues Drug / alcohol issues Relationship with Spouse / Partner

Medical Concerns or Conditions_____

Prescribed mental health medication: _____

Name of Prescriber _____ Circle: Primary Doctor, FNP, Psychiatrist, Other_____

Please note that there is much demand for appointments after 3 pm, if you absolutely need an ongoing appointment at this time, you may have a longer wait for a therapist.

Please indicate all the times you could be available to meet:

Day: 8 am thru 2 pm __ Monday, __ Tuesday, __ Wednesday, __ Thursday, __ Friday
Evening: 3 pm thru 8 pm __ Monday, __ Tuesday, __ Wednesday, __ Thursday, __ Friday

Would you meet by ___ Phone Tele-health, ___ Video Tele-health, ___ in Office

Are there any Special Needs for the Appointment (such as Handicap Access) ___Yes ___ No

- If you are hoping for a very specific treatment such as EMDR, Mindfulness, Cognitive, Solution-Focused, Family Therapy, etc. _____ (please tell us).

Would you circle your Religious Background: Christian, Baptist, Catholic, Episcopal, Lutheran, Methodist, Presbyterian, Pagan, Jewish, Muslim, Buddhist, None, Other_____

How were you referred to our office? (Circle one): Family, Friend, Clergy _____ (name) Physician _____ (name), School_____ (name), Legal Services, Social Services, Insurance or EAP, an Ad, the Internet, TV or Radio, a sign, or card on a Rack, Someplace else?_____

Samaritan Counseling Center

Name:	**Date:**
DOB:	**Age:**

Summary of Adult Symptom Screening – Please answer ALL questions

Over the last **2 weeks**, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless				
Little interest or pleasure in doing things				
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				

The following questions relate to your experiences over the last **6 months**:

	Yes	No
In the past 6 months, did you ever have a spell or an attack when all of a sudden you felt frightened, anxious or very uneasy?		
In the past 6 months, did you ever have a spell or attack when for no reason your heart suddenly began to race, you felt faint, or you couldn't catch your breath?		
Did any of these spells or attacks ever happen in a situation when you were not in danger or not the center of attention?		

Please respond to the degree that the following problems have bothered you during **the past week.**

	Not at all	A little bit	Somewhat	Very much
Fear of embarrassment causes me to avoid doing things or speaking to people.				
I avoid activities in which I am the center of attention.				
Being embarrassed or looking stupid are among my worst fears.				

Please answer each question to the best of your ability.

	Yes	No
Have you experienced any of the following traumatic events: natural disaster (e.g., flood, hurricane, tornado, earthquake), fire, explosion, or industrial accident; transportation accident (e.g., car accident, plane crash); physical assault (e.g., being attacked, beaten up); sexual assault (e.g., rape, attempted rape, made to perform any type of sexual act through force or threat of harm); captivity or exposure to a war-zone; life-threatening illness or injury; sudden, unexpected death of or injury to someone close to you; or serious injury, harm, or death to someone else that you witnessed or caused?		
Has this event caused any significant problems or symptoms that lasted for more than a month?		

Samaritan Counseling Center

Please answer each question to the best of your ability.

Has there ever been a period of time when you were not your usual self and...	Yes	No
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
...you were so irritable that you shouted at people or started fights or arguments?		
...you felt much more self-confident than usual?		

Has there ever been a period of time when you were not your usual self and...	Yes	No
...you got much less sleep than usual and found you didn't really miss it?		
...you were much more talkative or spoke much faster than usual?		
...thoughts raced through your head or you couldn't slow your mind down?		
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
...you had much more energy than usual?		
...you were much more active or did many more things than usual?		
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
...you were much more interested in sex than usual?		
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
...spending money got you or your family into trouble?		

The following questions relate to your **eating habits**:

	Yes	No
When you eat, do you make yourself sick because you feel uncomfortably full?		
Do you ever worry that you have lost control over how much you eat?		
Have you recently lost more than 14 pounds in a 3 month period?		
Do you believe yourself to be fat when others say you are too thin?		
Would you say that food dominates your life?		

	Yes	No
Have you ever been bothered by having to perform some ritual or act over and over that does not make sense?		

The following questions relate to your **alcohol and substance use:**

		Never (Skip the next 2 questions)	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
How often do you have a drink of Alcohol?						
		1 to 2	3 to 4	5 to 6	7 to 9	10 +
How many drinks containing alcohol do you have on a typical day when you are drinking?						

	Never	Less than monthly	Monthly	Weekly	Daly or almost daily
How often do you have six or more drinks on one occasion?					

	Yes	No
In the past year have you used an illegal drug or used a prescription medication for non-medical reasons?		

Please answer the questions below, rating yourself on each of the criteria shown using the scale provided. As you answer each question, select the option that best describes how you have felt and conducted yourself over the past **6 months**.

	Never	Rarely	Sometimes	Often	Very Often
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					

The questions listed below relate to your thoughts and feelings. If the way you have been in recent weeks or months differs from the way you usually are, please answer based on when you were **your usual self**.

	Yes	No
Do you find that most people will take advantage of you if you let them know too much about you?		
Do you generally feel nervous or anxious around people?		
Do you avoid situations where you have to meet new people?		
Do you avoid getting to know people because you're worried that they may not like you?		
Has avoidance of getting to know people due to fear of being disliked affected the number of friends that you have?		
Do you keep changing the way you present yourself to people because you don't know who you really are?		
Do you often feel like your beliefs change so much that you don't know what you really believe any more?		
Do you often get angry or irritated because people don't recognize your special talents or achievements as much as they should?		
Have you had any unusual experiences such as hearing voices, seeing visions, or having ideas you later found out were not true?		
Have you had any other experiences, such as mind reading, ESP, thoughts being controlled by others, seeing things on TV that refer to you specifically?		

Please complete and return to:
Samaritan Counseling Center
3001 E. Main St.
Endwell, NY 13760

***NOTE: you will not be contacted if all forms are not complete!**

Anything else you would like us to know?