

THE COASTAL SAMARITAN COUNSELING CENTER, INC.

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. Use a "✓" or an "x" to indicate your choices. Write in words or numbers where asked.

GENERAL INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_  
Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ . Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ .  Male  Female  
Street Address \_\_\_\_\_ Apt # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Telephone ( ) \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_ Other # \_\_\_\_\_  
Guardian/parent (if under 18) \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Reason for Referral \_\_\_\_\_  
Reason for choosing this Center \_\_\_\_\_  
Religious/denominational preference \_\_\_\_\_  
Your congregation/church/temple \_\_\_\_\_  
Your racial/ethnic identity:  African-American  Native-American  Asian-American  
 White/Caucasian  Hispanic  Other

EMPLOYMENT/EDUCATION INFORMATION

Full time employee \_\_\_\_\_ Full time at home \_\_\_\_\_ Part-time employee \_\_\_\_\_ Unemployed \_\_\_\_\_  
Place of employment \_\_\_\_\_ Length of Employment \_\_\_\_\_ Years  
Type of work you do \_\_\_\_\_  
Highest Level of Education Completed:  High School  College degree  Graduate degree  
 Professional training  Other \_\_\_\_\_

FAMILY INFORMATION

Relationships:  Single  Engaged  Married  Separated  Divorced  Widow(er)  Cohabiting  
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*: \_\_\_\_\_  
\_\_\_\_\_ Have any of your children died? \_\_\_\_\_

PAYMENT METHOD

Party responsible for payment, if other than client: Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Do you plan to file for insurance for these services?  Yes  No  Don't know  
Are you covered by an Employee Assistance Program?  Yes  No  Don't Know  
Do you wish to apply for fee assistance?  Yes  No

-over-

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**CLIENT INTAKE INFORMATION FORM (page 2)**

**PROBLEM DEFINITION**

What is your reason for seeking help now? \_\_\_\_\_

Are any of the following conditions a problem to you at this time? (Check the ones that apply)

<input type="checkbox"/> Anxiety
<input type="checkbox"/> Grief
<input type="checkbox"/> Depression
<input type="checkbox"/> Irrational fears
<input type="checkbox"/> Nervousness
<input type="checkbox"/> Loneliness
<input type="checkbox"/> Anger
<input type="checkbox"/> Marriage problems
<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Loss of work/job

<input type="checkbox"/> Self esteem
<input type="checkbox"/> Stress
<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Chronic fear
<input type="checkbox"/> Guilt feelings
<input type="checkbox"/> Suicidal feelings
<input type="checkbox"/> Loss of hope
<input type="checkbox"/> Rage
<input type="checkbox"/> Relationship to parents
<input type="checkbox"/> Relationship to children

<input type="checkbox"/> Loss of meaning in life
<input type="checkbox"/> Loss of faith in God
<input type="checkbox"/> Conflicts at work
<input type="checkbox"/> Religious doubts
<input type="checkbox"/> Other (list)
_____
_____
_____
_____
_____

What would you like to see happen as a result of psychotherapy or counseling?

\_\_\_\_\_

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**MEDICAL/PSYCHOLOGICAL HISTORY**

Name and address of your physician: \_\_\_\_\_

When was your last medical examination? \_\_\_\_\_

Are you suffering any physical illnesses or symptoms at this time? \_\_\_\_\_

List major surgeries or illnesses in the last five years: \_\_\_\_\_

\_\_\_\_\_

List current medications: \_\_\_\_\_

Have you or any member of your family received help for drug or alcohol dependency?  Yes  No

When? \_\_\_\_\_ Name of helping agency \_\_\_\_\_

Have you received psychotherapy or counseling in the past?  Yes  No. When? \_\_\_\_\_

Name of treating therapist: \_\_\_\_\_

Make a check mark if any of these statements are true:

Do you have thoughts of harming yourself or others?

Are thoughts of harming yourself or others a frequent occurrence?

Do you dwell on these thoughts and wonder if you can control them?

Have you sought professional help because of these thoughts or feelings?

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**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

\_\_\_\_\_  
DATE