Samaritan Counseling Center
OF NORTHEAST GEORGIA

CLIENT INFORMATION FORM

Client Information

First Name ______________________________ Middle ______________________________
Last Name ______________________________

Address ____
City ___________________State ____________ Zip Code _____________

Home Telephone (____)______________ Social Security No. ____/____/____
Work Telephone (____)______________ Birth Date ____/____/____ Age______
Cell Phone (____)______________ Sex: *Female* ☐ *Male* ☐
Fax Number (____)______________ Children: Names Age

________________ _____
Email ______________@_________________ ________________ _____
________________ _____

Client Status:

Circle one: Single Engaged Married (date ___/___/___) How long______
Divorced (date ___/___/___) How long______

Circle one: Employed full-time Employed part-time
Full-time student Part-time student

Education (Circle last year completed) 5 6 7 8 9 10 11 12
College/Technical School 1 2 3 4 Graduate School 1 2 3
Other Education/Training ____

Annual Household Income (circle one):
$0 - $9,999 $10,000 - $14,999 $15,000 - $29,000 $30,000 - $44,999 $45,000 - $59,999 $60,000+

Employer ____
Religious Preference ____
Referred by ____
Referral address and telephone ____

Insurance or HMO Information

Name of Insured ____
(Last) (First) (Middle I)

Insurance Company Name Insured's I.D. Number Group/Policy Number Social Security No.
_________________ _________________ _________________ ____/____/____

Authorization Number ______________________ Insured's Date of Birth ____/____/____

Insured's Address ____
City ______________________ State ____________ Zip ________________
Telephones: Home (____)___________ Work (____)__________ Cell (____)__________
Fax (____)_____________ Email _____________________________________
Sex: *Female* ☐ *Male* ☐

Employer or School Name ____
Claim Filing Address ____ Is there another insurance coverage? Yes No If yes, attach additional information.

I hereby authorize the release of any medical information necessary to process this insurance claim for reimbursement, and I authorize payments to be made to the provider.

Signature ____ *Date* ____/____/20____

Additional Responsible Party

First Name ________________________________ Middle ________________________________
Last Name ________________________________
Relation to Client: Circle one: Spouse Parent Other:
Address (if different from above)____
City______________________ State __________________ Zip __________________
Employer____

Home Telephone (____)______________ Social Security No. ____/____/____
Work Telephone (____)______________ Birth Date ____/____/____ Age______
Cell Phone (____)______________ Sex: *Female* *Male*
Fax Number (____)______________

Email ______________@___________________

Please describe the symptoms or reasons you are seeking counseling at this time:

Please describe the results or goals you want to achieve in the counseling process:

Medications you are taking: Prescribed By:
____________________________ ___________________________
____________________________ ___________________________
____________________________ ___________________________

Previous Therapy
When: With Whom:
_______________ ____________________________________
_______________ ____________________________________

Primary Care Physician: ____
Psychiatrist: ____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None= This symptom is not present at this time Mild= Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate= Significant impact on quality of life and/or day-to-day functioning Severe= Profound impact on quality of life and/or day-to-day functioning

Symptom	None	mild	moderate	severe
Appetite disturbance	Γ	Γ	Γ	Γ
Bingeing/purging	Γ	Γ	Γ	Γ
Laxative/diuretic abuse	Γ	Γ	Γ	Γ
Significant weight change	Γ	Γ	Γ	Γ
Anorexia	Γ	Γ	Γ	Γ
Grief	Γ	Γ	Γ	Γ
Physical complaints	Γ	Γ	Γ	Γ
Substance abuse	Γ	Γ	Γ	Γ
Paranoid thoughts	Γ	Γ	Γ	Γ
Dissociative states	Γ	Γ	Γ	Γ
Delusions/Hallucinations	Γ	Γ	Γ	Γ
Self harm	Γ	Γ	Γ	Γ
Suicidal thoughts	Γ	Γ	Γ	Γ

Symptom	None	mild	moderate	severe
Homicidal thoughts	Γ	Γ	Γ	Γ
Aggressive behaviors	Γ	Γ	Γ	Γ
Conduct problems	Γ	Γ	Γ	Γ
Emotional trauma victim	Γ	Γ	Γ	Γ
Sexual trauma victim	Γ	Γ	Γ	Γ
Physical trauma victim	Γ	Γ	Γ	Γ
Generalized anxiety	Γ	Γ	Γ	Γ
Obsessions/compulsions	Γ	Γ	Γ	Γ
Phobias	Γ	Γ	Γ	Γ
Panic attacks	Γ	Γ	Γ	Γ
Depressed mood	Γ	Γ	Γ	Γ
Irritability	Γ	Γ	Γ	Γ
Agitation	Γ	Γ	Γ	Γ
Social isolation	Γ	Γ	Γ	``Γ
Hopelessness	Γ	Γ	Γ	Γ

Symptom	None	mild	moderate	severe
Worthlessness	Γ	Γ	Γ	Γ
Guilt	Γ	Γ	Γ	Γ
Sleep disturbance	Γ	Γ	Γ	Γ
Poor concentration	Γ	Γ	Γ	Γ
Fatigue/low energy	Γ	Γ	Γ	Γ
Elevated mood	Γ	Γ	Γ	Γ
Hyperactivity	Γ	Γ	Γ	Γ
Increased emotional reactions	Γ	Γ	Γ	Γ
Mood swings	Γ	Γ	Γ	Γ
Sexual dysfunction	Γ	Γ	Γ	Γ
Sexual Identity concerns	Γ	Γ	Γ	Γ
Other (specify) ________________	Γ	Γ	Γ	Γ

Have you ever pushed, yelled at or hit someone? ____
Have you accidently ever hurt someone?____
Who makes decisions at your house? ____
Have you ever been involved with the Family and Children Services? If so, explain ____________________________

SUBSTANCE USE HISTORY (check all that apply)

Family alcohol/drug use history:

Γ father Γ stepparent/live-in
Γ mother Γ uncle(s)/aunt(s)
Γgrandparent(s) Γ spouse/significant
Γ sibling(s) Γ children
Γ other ______________________

Substances used: First use age Last use age Current Use? Current frequency Current (Yes/No)

____
____
____
____

Client substance abuse status:
Γ no history of abuse
Γ active abuse
Γ early partial remission
Γ long term remission

Consequences of substance use (check all that apply):
Γ hangovers Γ withdrawal symptoms Γ sleep disturbances
Γ seizures Γ medical complications Γ assaults
Γ blackouts Γ tolerance changes Γ suicidal impulse
Γ overdose Γ loss of control amount used
Γ binges Γjob loss Γ arrests
Γ relationship conflicts Γ other:______________________

Treatment history:
Γ outpatient (age(s)____________)
Γ inpatient (age(s)_____________)
Γ 12-step program (age(s)________)
Γ stopped on own (age(s) ________)
Γ other (age(s)__) describe: ______

SOCIO-ECONOMIC HISTORY (check all that apply)

Describe childhood family experience:
G Outstanding home environment
G Normal home environment
G Chaotic home environment
G Witnessed physical/verbal/sexual problem:______________________
G Experienced physical/verbal/sexual abuse from others ________________

Military history:
G Never in military
G Served in military—no incident
G Served in military *with* incident

Cultural/spiritual/recreational history:

Cultural identity (e.g., ethnicity, religion):__________________________
Describe any cultural issues that contribute to current problem ____________________
____
Formerly active in community/recreational activities? YesG NoG
Currently active in community/recreational activities? YesG NoG
Currently engage in hobbies? YesG NoG
Currently participate in spiritual activities? YesG NoG

Legal history:
If answered "yes" to any of above, describe:_____________________

G No legal problems
G Now on parole/probation
G Arrest(s) not substance-related
G Arrest(s) substance-related
G Court ordered this treatment
G Jail/prison______time(s)
Total time served:__________
Describe last legal difficulty___
____
____

Is there anything else you would like us to know? ____

Are you interested in receiving holistic services which incorporate yoga, nutritional strategies, and meditation to integrate with your counseling? If so, please let our front desk staff personnel know!

Agreement for Services at Samaritan Counseling Center of Northeast Georgia

Agreement to Receive Counseling

I have requested and agree to receive counseling and psychotherapy services with one or more staff, intern, or resident counselors or the Samaritan Counseling Center of Northeast Georgia

I have been given information about the qualifications and training of the counselor(s) with whom I will be in counseling

Fees and Payment

I understand that:

- There is a fee for professional counseling services and that fee has been explained to me. I agree to pay the fee as explained ($125.00 per intake and assessment session, $105.00 per 50 minute session, $55 per 20-30 minute session, $125.00 for after hours services) and to pay at the end of each session unless other arrangements are made (list here):

_____ Ins./Co-pay $____________ _____ CAF/Client Fee $____________

_____ Full Pay _____ Responsible Party $____________

- Fees for group therapy sessions are charged as long as one is a member or the group, regardless of the attendance and/or notification of absence.
- Fees are charged for extended discussions over the telephone.
- Fees are charged for related services such as written reports, consultation with other professionals, and testing.
- ***Fees are charged for missed appointments or for appointments canceled within twenty-four (24) hours of the time of the appointment.***

Confidentiality

I understand that counseling is confidential with the following exceptions:

1. The legal limits mentioned in the Counseling, Fee, and Privacy Policy Statement which includes clear and imminent danger to self or others which I have been given
2. Where I have given written permission for release of information
3. When material from a counseling interview is discussed with other Samaritan clinical staff and/or health professionals for supervision or consultation
4. When I or the responsible party have not paid the amount due and collection procedures are necessary
5. When I have signed a Release of Confidential Information for information required by my health insurance or managed care company (for a copy of the information shared with the insurance company, ask your counselor)

I have been given a copy of the Counseling, Fee, and Privacy Policy Statement. In signing this Agreement, I specifically incorporate the agreements and information in the Counseling, Fee, and Privacy Policy Statement.

Client Signature:____ Date:________________

Client Signature:____ Date:________________

Parent/Guardian Signature:________________________________ Date:________________

Counselor Signature:_____________________________________ Date:________________