Samaritan Counseling Center
OF NORTHEAST GEORGIA

CLIENT INFORMATION FORM

Client Information

First Name ______________________________ Middle ______________________________
Last Name ______________________________

Address ____
City ____________________ State ____________ Zip Code _____________

Home Telephone (____)______________
Work Telephone (____)______________
Cell Phone (____)______________
Fax Number (____)______________

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

Social Security No. ____/____/____
Birth Date ____/____/____ Age______
Sex: *Female* ☐ *Male* ☐

Email _______________@___________________

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

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

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

	None	mild	moderate	severe		None	mild	moderate	severe		None	mild	moderate	severe
Depressed mood	☐	☐	☐	☐	Bingeing/purging	☐	☐	☐	☐	Guilt	☐	☐	☐	☐
Appetite disturbance	☐	☐	☐	☐	Laxative/diuretic abuse	☐	☐	☐	☐	Elevated mood	☐	☐	☐	☐
Sleep disturbance	☐	☐	☐	☐	Anorexia	☐	☐	☐	☐	Hyperactivity	☐	☐	☐	☐
Elimination disturbance	☐	☐	☐	☐	Paranoid ideation	☐	☐	☐	☐	Dissociative states	☐	☐	☐	☐
Fatigue/low energy	☐	☐	☐	☐	Circumstantial symptoms	☐	☐	☐	☐	Physical complaints	☐	☐	☐	☐
Psychomotor retardation	☐	☐	☐	☐	Loose associations	☐	☐	☐	☐	Self-mutilation	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐	Delusions	☐	☐	☐	☐	Significant weight gain/loss	☐	☐	☐	☐
Poor grooming	☐	☐	☐	☐	Hallucinations	☐	☐	☐	☐	Concomitant medcl. Condition	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐	Aggressive behaviors	☐	☐	☐	☐	Emotional trauma victim	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	Conduct problems	☐	☐	☐	☐	Physical trauma victim	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐	Oppositional behavior	☐	☐	☐	☐	Sexual trauma victim	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	Sexual dysfunction	☐	☐	☐	☐	Emotional trauma perpetrator	☐	☐	☐	☐
Generalized anxiety	☐	☐	☐	☐	Grief	☐	☐	☐	☐	Physical trauma perpetrator	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐	Hopelessness	☐	☐	☐	☐	Sexual trauma perpetrator	☐	☐	☐	☐
Phobias	☐	☐	☐	☐	Social isolation	☐	☐	☐	☐	Substance abuse/use	☐	☐	☐	☐
Obsessions/compulsions	☐	☐	☐	☐	Worthlessness	☐	☐	☐	☐	Other (specify)	☐	☐	☐	☐

SUBSTANCE USE HISTORY (check all that apply for patient)

Family alcohol/drug use history:

☐ father ☐ stepparent/live-in
☐ mother ☐ uncle(s)/aunt(s)
☐ grandparent(s) ☐ spouse/significant other
☐ sibling(s) ☐ children
☐ other ______________________________

Client substance abuse status:

☐ no history of abuse
☐ active abuse
☐ early full remission
☐ early partial remission
☐ sustained full remission
☐ sustained partial remission

Treatment history:

☐ outpatient (age(s)____________________)
☐ inpatient (age(s)_____________________)
☐ 12-step program (age(s)______ ________)
☐ stopped on own (age(s)_______________)
☐ other (age(s)_______) describe: ________
____

Substances used:

(complete all that apply)

	First use age	Last use age	Current Use? (Yes/No)	Current frequency	Current amount
☐ alcohol	_______	_______	____	_______	_______
☐ amphetamines/“speed”	_______	_______	____	_______	_______
☐ barbiturates/“downers”	_______	_______	____	_______	_______
☐ caffeine	_______	_______	____	_______	_______
☐ cocaine	_______	_______	____	_______	_______
☐ crack cocaine	_______	_______	____	_______	_______
☐ hallucinogens (e.g., LSD)	_______	_______	____	_______	_______
☐ inhalants (e.g., glue, gasoline)	_______	_______	____	_______	_______
☐ marijuana or hashish	_______	_______	____	_______	_______
☐ nicotine/cigarettes	_______	_______	____	_______	_______
☐ PCP	_______	_______	____	_______	_______
☐ prescription ______________	_______	_______	____	_______	_______
☐ other ___________________	_______	_______	____	_______	_______

Consequences of substance use (check all that apply):

☐ hangovers ☐ withdrawal symptoms ☐ sleep disturbance ☐ binges
☐ seizures ☐ medical complications ☐ assaults ☐ job loss
☐ blackouts ☐ tolerance changes ☐ suicidal impulse ☐ arrests
☐ overdose ☐ loss of control amount used ☐ relationship conflicts

☐ other:____

SOCIO-ECONOMIC HISTORY (check all that apply for patient)

Describe childhood family experience:

☐ Outstanding home environment
☐ Normal home environment
☐ Chaotic home environment
☐ Witnessed physical/verbal/sexual abuse toward others
☐ Experienced physical/verbal/sexual abuse from others

Military history:

☐ never in military
☐ served in military—no incident
☐ served in military with incident
____

Cultural/spiritual/recreational history:

Cultural identity (e.g., ethnicity, religion):________________
____

describe any cultural issues that contribute to current problem:____
____

currently active in community/recreational activities? Yes☐ No☐
formerly active in community/recreational activities? Yes☐ No☐
currently engage in hobbies? Yes☐ No☐
currently participate in spiritual activities? Yes☐ No☐

if answered “yes” to any of above, describe:________________
____
____

Legal history:

☐ no legal problems
☐ now on parole/probation
☐ arrests(s) not substance-related
☐ arrest(s) substance-related
☐ court ordered this treatment
☐ jail/prison______time(s)
total time served:____________
describe last legal difficulty____
____

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 are charged for missed appointments or for appointments canceled within twenty-four (24) hours of the time of the appointment.
- 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.

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:_________________