

Therapist \_\_\_\_\_

File No. \_\_\_\_\_  
(For office use only)

## SAMARITAN COUNSELING CENTER OF ALBUQUERQUE

The information asked for below is to help us understand you and your concerns. Please fill out this form as completely as you can. All information is confidential.

**Today's Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_  
(First) (Middle) (Last)

**Address:** \_\_\_\_\_  
\_\_\_\_\_  
(City) (State) (County) (Zip)

**Telephone:** \_\_\_\_\_  
(Home) (Work) (Cell)

**Birth Date:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:**  Male  Female

**Social Security No.:** \_\_\_\_\_

**School** (if applicable): \_\_\_\_\_ **Grade:** \_\_\_\_\_  Full Time Student  
 Part Time Student

**Employer:** \_\_\_\_\_  Full Time  
 Part Time

**Emergency Contact:** \_\_\_\_\_  
(Required) (Name) (Relationship) (Daytime Phone) (Evening Phone)

**Religious Preference:** \_\_\_\_\_ **Congregation Attended:** \_\_\_\_\_  
(If any)

**Who referred you to Samaritan Counseling Center?**

\_\_\_\_ Clergy \_\_\_\_ Doctor \_\_\_\_ Internet \_\_\_\_ Family/Friend \_\_\_\_ Attorney/Court  
\_\_\_\_ Insurance \_\_\_\_ School \_\_\_\_ Former Client \_\_\_\_ Media \_\_\_\_ Other (Please Specify)

**Payment Responsibility:**

- Insurance Company: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_  
Social Security No. of Policy Holder: \_\_\_\_\_  
Birth Date of Policy Holder: \_\_\_\_\_
- Self Pay
- Bill to third party: \_\_\_\_\_

**Marital Status:** \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed  
\_\_\_\_\_ Divorced \_\_\_\_\_ Separated

**Date of Present Marriage** (If Applicable): \_\_\_\_\_ (Month/Day/Year)

**Spouse's Name** \_\_\_\_\_ **Spouse's Occupation** \_\_\_\_\_

**Previous Marriage(s)** (dates, how terminated): \_\_\_\_\_  
\_\_\_\_\_

<b>Children:</b>	<b>Name</b>	<b>Age</b>
	_____	_____
	_____	_____
	_____	_____

**Any children deceased?** \_\_\_\_\_ **If yes, when?** \_\_\_\_\_

**Parent(s) / Guardian(s) if under 18:** \_\_\_\_\_

**Physician:** \_\_\_\_\_ (Name) \_\_\_\_\_ (Address) \_\_\_\_\_ (Phone)

**Education:** (indicate last grade completed/last degree earned): \_\_\_\_\_

**Military Service:** \_\_\_\_\_ **Date(s):** \_\_\_\_\_

**FAMILY BACKGROUND**

**Father's Name** \_\_\_\_\_ **Age:** \_\_\_\_\_ **If deceased, when?** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **If deceased, when?** \_\_\_\_\_

<b>Brothers &amp; Sisters</b>	<b>Name</b>	<b>Age</b>
	_____	_____
	_____	_____
	_____	_____

**Are any deceased?** \_\_\_\_\_ **If yes, who & when?** \_\_\_\_\_

**MEDICAL INFORMATION**

Please list any health problems you currently have: \_\_\_\_\_

Please list any health problems you have had in the past, including operations: \_\_\_\_\_

Do you have any allergies?  Yes  No

If so, what? \_\_\_\_\_

Have you had previous therapy?  Yes  No

If yes, when & with whom? \_\_\_\_\_

Are you presently seeing another therapist?  Yes  No

If yes, name of therapist: \_\_\_\_\_

Do you presently take any medications?  Yes  No

If yes, what? \_\_\_\_\_

For what conditions? \_\_\_\_\_ Prescribed by: \_\_\_\_\_

Length of time of medications: \_\_\_\_\_

**CONCERNS**

Please describe the concerns that you bring to counseling: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Check The Items Below That Describe or Relate to the Concerns Mentioned Above:**

- \_\_\_\_\_ Anxiety
- \_\_\_\_\_ Bereavement
- \_\_\_\_\_ Depression
- \_\_\_\_\_ Nervousness
- \_\_\_\_\_ Loneliness
- \_\_\_\_\_ Job/Employment
- \_\_\_\_\_ Sexual concerns
- \_\_\_\_\_ Substance abuse (alcohol or drug)
- \_\_\_\_\_ Marriage/Relationship
- \_\_\_\_\_ Divorce/Custody
- \_\_\_\_\_ Legal

- \_\_\_\_\_ Anger
- \_\_\_\_\_ Self esteem issues
- \_\_\_\_\_ Fear
- \_\_\_\_\_ Self doubt
- \_\_\_\_\_ Guilt
- \_\_\_\_\_ Suicidal feelings
- \_\_\_\_\_ Relationship with parents
- \_\_\_\_\_ Relationship with children
- \_\_\_\_\_ Confusion
- \_\_\_\_\_ Blended Family

- \_\_\_\_\_ Religious concerns
- \_\_\_\_\_ Loss of faith in God
- \_\_\_\_\_ Loss of faith in self
- \_\_\_\_\_ Loss of faith in others
- \_\_\_\_\_ Loss of hope
- \_\_\_\_\_ Loss of meaning
- \_\_\_\_\_ Loss of self respect
- \_\_\_\_\_ Loss of love
- \_\_\_\_\_ Personal growth
- \_\_\_\_\_ Other