SAMARITAN CENTER OF THE ROCKIES
CLIENT INTAKE INFORMATION FORM

Name: _____ Date: _____

Physical Address: _____ Home Phone: _____

Mailing Address: _____ E-Mail Address _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Education: _____ Ethnicity: _____

Are you currently involved in any legal action? _____ Yes _____ No

If yes, please describe: _____

How did you hear about the Samaritan Center

___ REFERRED BY FRIEND _____ WEBSITE
___ YELLOW PAGES _____ VAIL DAILY
___ REFERRED BY DOCTOR, IF SO DOCTOR'S NAME: _____
___ REFERRED BY PASTOR, IF SO PASTOR'S NAME: _____
___ OTHER, PLEASE SPECIFY _____

_____ PLEASE INCLUDE ME ON YOUR MAILING LIST FOR E-NEWSLETTERS

FAMILY HISTORY

Marital Status: _____ Mar _____ Wid _____ Sgl _____ Div _____ Sep

Spouse's Name: _____ Age: _____

Date of Marriage: _____ Dates of Previous Marriages: _____

Children	Age	Sex
_____	____	____
_____	____	____
_____	____	____
_____	____	____

Father's Name: _____ Deceased? _____ When _____

Mother's Name: _____ Deceased? _____ When _____

Did your parent's divorce? _____ When _____

Where were you born? _____ Raised _____

Siblings:	Age	Sex	Deceased? (Date)
_____	____	____	_____
_____	____	____	_____
_____	____	_____	_____

Emergency Contact Information

Name:_____Phone:_____

MEDICAL HISTORY

PHYSICIAN: _____

SIGNIFICANT MEDICAL PROBLEMS? _____

_____ DATE OF YOUR LAST EXAM?_____

CURRENT MEDICATION FOR WHAT CONDITION PRESCRIBED BY

_____

_____

_____

DO YOU CONSUME ALCOHOL / DRUGS? WHICH FREQUENCY(times/week)

_____

_____

PREVIOUS THERAPIST(S): WHEN FOR WHAT CONCERN

_____

_____

WHAT DO YOU BELIEVE IS YOUR PHYSICAL CONDITION AT THIS TIME?

POOR FAIR AVERAGE GOOD EXCELLENT

WHAT DO YOU BELIEVE IS YOUR EMOTIONAL CONDITION AT THIS TIME?

POOR FAIR AVERAGE GOOD EXCELLENT

On the following list, please circle any you are experiencing:

ANXIETY ANGER DEPRESSION SUICIDAL THOUGHTS SADNESS FEAR LONELLINESS MARITAL PROBLEMS NUMBNESS PAIN SELF DOUBT PANIC SEXUAL CONCERNS VOMITING GUILT NERVOUSNESS EATING PROBLEMS FATIGUE SLEEP PROBLEMS NIGHTMARES LOSS OF A LOVED ONE LOSS OF FAITH IN: GOD SELF OTHERS

WHY ARE YOU SEEKING COUNSELING AT THIS TIME?

_____

_____

_____

HOW IMPORTANT IS YOUR PRACTICE OF FAITH OR SPIRITUAL LIFE?

VERY IMPORTANT SOMEWHAT IMPORTANT NOT IMPORTANT

RELIGIOUS PREFERENCE: _____ CHURCH ATTEND: _____