



SAMARITAN COUNSELING CENTER

1803 Oregon Pike Lancaster, PA 17601 717-560-9969 Fax 717-560-9553

CLIENT SELF-REPORT FORM

THE INFORMATION ASKED FOR BELOW IS TO HELP US BETTER UNDERSTAND YOU. PLEASE FILL OUT THIS FORM AS COMPLETELY AS YOU CAN. ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE.

GENERAL INFORMATION

Date: _____ Date of Birth: _____ Age: _____

Name: _____
Title (Mr/Mrs/Ms/etc.) First Middle Last

Address/City/State/Zip: _____

Phone: (Home) _____ Work) _____ (Cell) _____

Employer/School: _____ Occupation/Grade: _____

Education: (Last grade completed/last degree earned): _____

Who Referred You To Samaritan Center? _____
It is our practice to thank professional referral sources: for example clergy, doctors.

Who Will Be Responsible For Payment? _____

FAMILY INFORMATION

Father: _____
Name Age Deceased? Date of death Your age at time of his death

Mother: _____
Name Age Deceased? Date of death Your age at time of her death

Were your parents divorced? Yes ___ No ___ If so: what age were you when they divorced? _____

BROTHERS AND SISTERS:

Name	Age	Sex	Deceased? (date)	Biological, adopted, step or half sibling
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Check which of the following were diagnosed or treated in your family. (list if suspected and details unknown)
Depression _____ Anxiety _____ Bipolar _____ OCD _____ Phobias _____ Other _____

Is there a history of alcohol or drug abuse in your family? Please specify: _____

PERSONAL INFORMATION

Married? _____ How long? _____ Significant Relationship? _____ How long? _____

Spouse Or Partner's Name: _____ Age: _____

Previous Marriages: Dates: from: _____ to: _____

Dates: from: _____ to: _____

Significant Relationships:

Dates: from: _____ to: _____

Dates: from: _____ to: _____

Did you serve in the Military? _____ Combat? _____ Dates: _____

Did You Ever Have Problems With Alcohol Or Drug Use?

Yes _____ No _____ Describe: _____

Has anyone ever physically hurt you? Yes _____ No _____

Has anyone ever forced or pressured you to participate in sexual activities when you did not want to?

Yes _____ No _____

Are you currently or have you ever been in a relationship in which: (check all that apply)

_____ you are threatened or you feel afraid? _____ you are insulted, put down?

_____ you are belittled? _____ you feel controlled?

CHILDREN					
Name	Biological, adopted or step	Age	Sex	Married	Children
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have any children died? _____ Yes _____ No If yes, please give details: _____

History of legal charges or arrests? If yes, explain including dates: _____

SPIRITUAL HISTORY

If any, with which place of worship are you currently affiliated? _____ None _____

Was religion important in your family of origin? Yes _____ No _____

Do you draw on spiritual/religious beliefs to cope with life situations? Yes _____ No _____ If yes, in what way? _____

MEDICAL INFORMATION

When, if ever, have you had previous therapy? _____ With Whom? _____

Are you presently seeing a psychiatrist or another therapist? _____

Name of psychiatrist or therapist: _____ Name of Primary Care Doctor: _____

Current medication:	Dosage?	What condition?	Prescribed by?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any psychiatric hospitalizations with dates: _____

List any surgeries with dates: _____

Have you ever had a head injury? Yes _____ No _____ Specify: _____

CURRENT CONCERNS:

What do you consider your most significant difficulty or problem? _____

Check any of the following that causes you difficulty:

- | | |
|--|---|
| _____ Depression | _____ Poor sleep |
| _____ Sadness | _____ Change in appetite or weight issues |
| _____ Frequent crying | _____ Thoughts of self harm |
| _____ Abnormal elevated mood | _____ Thoughts of harming others |
| _____ Constant worries | _____ Difficulty making decisions |
| _____ Anxiety | _____ Relationship issues |
| _____ Fear | _____ Work/career issues |
| _____ Rapid and repeating thoughts | _____ Anger management |
| _____ Health concerns: (Describe): _____ | |