



*REQUIRED FIELDS		*Today's Date:		Samaritan Center ID:					
CLIENT INFORMATION (please print)									
*Client's Last Name:		*First: Middle:		☐ Mr. ☐	Miss	*Marital status (circle one)			
				☐ Mrs. ☐	Ms.	Single / Mar / Div / Sep / Wid			
*Is the "Primary Client" an 🔲 Adult 🔲 Adolescent 🗀 Child				*Client Date of Birth: *Age: *Sex:					
If client is a minor, name of responsible party:					/	/		$\square$ M	□F
*Street Address:			Social Security Numb	Security Number.: *Home Phone: ( )					
						*OK to leave message? YES			_NO
P.O. Box: *City:			*State:	*ZIP Code	:	*Cell Phone: ( )			
						*OK to leave message? YES NO			
Occupation: *Employer:				Employer Phone: ( )					
			OK to leave message?YESN					_NO	
*I learned about SCC from:	ring by D Internet		Pastor		☐ Othe	🗖 Insurar	nce Plan	Family/	Friend
	SCC from: ☐ Driving by ☐ Internet ☐ Area Agency: ☐ Other ☐ Other family members seen here: Religious Preference/Denomination:								
*Method of Payment: ☐ Client Pay ☐ Insurance ☐ Voucher ☐ Employee Assistance Program (EAP) ☐ Client Assistance Fund									
		GENERAL CONSE	ENT TO COUN	SELING					
*I (print name),Counseling of Michia I consent to begin counse with Seasons Counseling of I understand that this doc that a copy or duplicate of does not contain an origin equivalent of this original I agree that I am responsithese services. I agree the regular payments will initi will be responsible for all 40% or more of my account have been informed of response to the services.	uma's Notice of eling, including evor Michiana staff a ument may be sea this original docural writing of my sidocument for all puble for the payment I am financially ate monthly interesting attorney ant.	aluation, treatment and/ond authorized profession and authorized profession anned into a computer system that shall have the same and grature. I further acknow purposes.  Int of all services rendered y responsible for failed agest charges until the accounties and/or collection feel.	IPAA).  or referral. I authorical consultants and so tem or converted in force, effect and valid eledge that a copy or dome. In the event topointments or cane that is paid. If the determinant is paid. If the determinant is collected in collected in collected in collected in the second in the sec	ze that mate upervisors.  to electronic dity as the or duplicate of that my insurcelled appoint cision is maceting an over	, have rial from a or digital documents documents will attend to turn due balant	the counseling state of the counseling state of the counseling state of the counseling state of the count of the count of the count of the account over the account over the account over the counter of	sessions mader acknown ugh said concerned to be ayment, I is notice.	ay be discledge an opy or dise the fur agree to Failure to ection ag	d agree aplicate actional pay for o make gency, I
*Client or Parent/Guard		ature of the problem	you are experien	cing (be a	s specifi	*Date c as possible	<b>)</b> :		

	Symptoms (check all that ap	oply):
Poor Concentration	Indecision	Shy With People
Appetite increase/decrease	Feel Tense	Sleeping too much/not enough
Use food for comfort	Weight loss/gain	Loss of interest
No Appetite	Frequent Crying	Loss of energy
Suicidal Thoughts	Suicidal plans	Sadness
Passivity	Fears and Phobias	Home Conditions Bad
Over-Eating	Depressed	Unable To Have A Good Time
Stomach Trouble	Obsessions	Always Worried About Something
Bowel Disturbances	Too much energy	Don't Like Weekends/Vacations
Always Tired	Take Tranquilizers	Can't Make Decisions
Always Sleepy	Alcoholism	Over-Ambitious
Unable To Relax		Financial Problems
	Dangerous Drugs	
Grief/loss	Allergy	Gambling
Recurrent Dreams	Asthma	Job Problems
Nightmares	Anger issues	Can't Keep A Job
Hallucinations	Sexual Difficulties/Questions	Verbal abuse, past or present
Sexual abuse, past or present	Thoughts of hurting others	Plans to hurt others
Others (please list):		
Carers (prease not).		
	Dhysical Symptoms (sheely all the	ot amply).
	Physical Symptoms (check all tha	at apply):
Tired	Pain	Headaches
Dizziness	Numbness/Tingling	Stomach problems
Rapid Heart Beat	Memory Loss	Other:
	<del></del>	<del></del>
Stressors	you have experienced in the past two ye	ars (check all that apply):
☐ Job loss ☐ Death of Spo		☐ Job Loss ☐ New Home
☐ Divorce/Separation ☐ Job difficultie		☐ Victim of crime ☐ Personal illness
☐ Illness in family ☐ Pregnancy in		☐ Work difficulties ☐ Lost pregnancy
Other:	ranniy - School difficulties	■ Work difficulties ■ Lost pregnancy
Utner:		
	T 07 1 1 1 1 1	
	Focus of Treatment (check all that	1 <del></del> '
Anger Management	Anti social behavior	Anxiety
Anger Management Chemical Dependency	Anti social behavior Chemical dependency relapse	Childhood trauma
		<b>⊢</b>
Chemical Dependency Dependency	Chemical dependency relapse Depression	Childhood trauma Anxiety and/or panic
Chemical Dependency Dependency Eating Disorder	Chemical dependency relapse Depression Family Conflict	Childhood trauma Anxiety and/or panic Grief/loss
Chemical Dependency Dependency Eating Disorder Relationship Conflict	Chemical dependency relapse Depression Family Conflict Financial/legal issues	Childhood trauma Anxiety and/or panic Grief/loss Medical issues
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