SAMARITAN COUNSELING CENTER
1803 OREGON PIKE
LANCASTER, PA 17601
717-560-9969

APPOINTMENT DATE:____________
APPOINTMENT TIME:____________
THERAPIST:____________________

LOCATION: ☐ 1803 OREGON PK, LANCASTER ☐ 810 DONEGAL SPRINGS RD, MOUNT JOY

ADULT 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:____________________ SS#:____________________ 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?____

Insurance Plan Name:________________________ID#:________________________Group#:___________

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, half?

PERSONAL INFORMATION

☐ Single ☐ Married/Partner ☐ Divorced ☐ Widowed ☐ Significant Relationship How long?______

Spouse Or Partner's Name:____ Age:____________________

Dates of Previous Marriages or Significant Relationships: (1) From:______________To:________________

(2) From:______________To:________________

(3) From:______________To:________________

Did you serve in the Military?______________Combat?____________Dates:_____________________________

Did you ever have problems with alcohol or drug use? Yes__________ No_________

Have you ever received any help for your use of alcohol or drugs? Yes_______ No__________ If yes, where

and when:____

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/Significant Relationship	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

Are you, or were you, associated with a spiritual/religious community, group or place of worship?____________

What is the name?____

What spiritual/religious beliefs or practices, if any, do you draw on for comfort and strength?________________

____

What spiritual/religious experiences, if any, have harmed you psychologically, emotionally?________________

____

What, if any, spiritual/religious concerns do you wish to include in your counseling?_______________________

____

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:____

Do you have any medication allergies? ☐ Yes ☐ No Specify medication(s) and reaction(s):___________________

____

Do you have any other allergies? ☐ Yes ☐ No Specify type(s) and reaction(s):_____________________________

____

Have **you** or anyone in your **family of origin** ever had the following? (For family, list your relationship to the person)

	Self?	**Family?**	**Relationship**
ADHD	☐ Yes ☐ No	☐ Yes ☐ No	__________________
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	__________________
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	__________________
Type?	________________	________________	
Cardiac Disease	☐ Yes ☐ No	☐ Yes ☐ No	__________________

	Self?		Family?		Relationship
Chronic Lung Disease	☐ Yes	☐ No	☐ Yes	☐ No	________________
Cystic Fibrosis	☐ Yes	☐ No	☐ Yes	☐ No	________________
Dementia/Alzheimer's	☐ Yes	☐ No	☐ Yes	☐ No	________________
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No	________________
Fibromyalgia	☐ Yes	☐ No	☐ Yes	☐ No	________________
High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No	________________
High Cholesterol	☐ Yes	☐ No	☐ Yes	☐ No	________________
Irritable Bowel	☐ Yes	☐ No	☐ Yes	☐ No	________________
Kidney Disease	☐ Yes	☐ No	☐ Yes	☐ No	________________
Migraine Headaches	☐ Yes	☐ No	☐ Yes	☐ No	________________
Peptic Ulcer	☐ Yes	☐ No	☐ Yes	☐ No	________________
Rheumatoid Arthritis	☐ Yes	☐ No	☐ Yes	☐ No	________________
Stroke	☐ Yes	☐ No	☐ Yes	☐ No	________________
Thyroid Disease	☐ Yes	☐ No	☐ Yes	☐ No	________________
Tuberculosis	☐ Yes	☐ No	☐ Yes	☐ No	________________
Addictions	☐ Yes	☐ No	☐ Yes	☐ No	________________
Type?	________________		________________		
Type?	________________		________________		
Anxiety	☐ Yes	☐ No	☐ Yes	☐ No	________________
Bipolar	☐ Yes	☐ No	☐ Yes	☐ No	________________
Depression	☐ Yes	☐ No	☐ Yes	☐ No	________________
OCD	☐ Yes	☐ No	☐ Yes	☐ No	________________
Phobias	☐ Yes	☐ No	☐ Yes	☐ No	________________
Schizophrenia	☐ Yes	☐ No	☐ Yes	☐ No	________________
Suicide Attempts	☐ Yes	☐ No	☐ Yes	☐ No	________________
Suicide (Completed)			☐ Yes	☐ No	________________

Other significant personal or family health issues:____

____

CURRENT CONCERNS:

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

____

____

____

Check any of the following that causes you difficulty:

_______Depression
_______Sadness
_______Frequent crying
_______Constant worries
_______Anxiety
_______Fear

_______Poor sleep
_______Rapid and repeating thoughts
_______Abnormal elevated mood
_______Change in appetite or weight issues
_______Thoughts of self harm

_______Thoughts of harming others
_______Difficulty making decisions
_______Relationship issues
_______Work/career issues
_______Anger management
_______Health concerns (describe):

____