# SAMARITAN COUNSELING CENTER

1803 OREGON PIKE • LANCASTER, PA 17601 • 717-560-9969 • FAX 717-560-9553

## *CLIENT UPDATE FORM*

THE INFORMATION BELOW IS REQUESTED IN ORDER TO KEEP YOUR FILE INFORMATION CURRENT. PLEASE FILL OUT THIS FORM AS COMPLETELY AS YOU CAN. ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE.

Date:_____ Date of Birth:_____ Social Security Number:_____

Client Name:_____ Name of Person Completing Form if Client is Child:_____
First Middle Last

Address:_____ City, State, Zip:_____

Phone:(H)_____ (W)_____ (C)_____

Employer/School:_____ Occupation/Grade:_____

Health Insurance Company:_____ Who Will Be Responsible For Payment?_____

If the Client is a Child, has there been any change in legal custody?_____ If yes, we will need consent of both parties as well as a copy of the custody agreement.

***If Samaritan Counseling Center is an in-network provider with your insurance company, please provide us with your current insurance card and complete the information requested below.***

Is The Policy In Your Name?_____ If No, List the Policyholder's name, Date of Birth and Social Security Number:

Name:_____ Date of Birth:_____ SSN:_____

Plan Name:_____ Policy Number:_____ Group Number:_____

If Medicare, list the secondary insurance information (Company, identification number, claim address, phone number):
Plan Name:_____ Policy Number:_____ Phone Number:_____

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

What is your current relationship status? ☐ Single ☐ Married/Partner ☐ Divorced ☐ Widowed ☐ Significant Relationship

Since your last appointment, have there been any changes in your:

_____Health _____Relationship Status _____Drug/Alcohol Use _____Legal Charges/Arrests? If yes to any, please explain:_____

Check any of the following that causes you/your child 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):_____

| Current medication: | Dosage? | What condition? | Prescribed by? |
|---|---|---|---|
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