

SAMARITAN COUNSELING CENTER APPOINTMENT DATE/ TIME: _____

1803 OREGON PIKE _____

LANCASTER, PA 17601 _____

717-560-9969 THERAPIST: _____

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: _____ 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Type?	_____	_____	
Cardiac Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Chronic Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cystic Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Dementia/Alzheimer's	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Self?

Family?

Relationship

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Irritable Bowel	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Peptic Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Addictions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Type? _____

Type? _____

Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bipolar	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
OCD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Phobias	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Suicide Attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Suicide (Completed)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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	_____ Poor sleep	_____ Thoughts of harming others
_____ Sadness	_____ Rapid and repeating thoughts	_____ Difficulty making decisions
_____ Frequent crying	_____ Abnormal elevated mood	_____ Relationship issues
_____ Constant worries	_____ Change in appetite or weight	_____ Work/career issues
_____ Anxiety	_____ issues	_____ Anger management
_____ Fear	_____ Thoughts of self harm	_____ Health concerns (describe):