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 of client:_____

Client name:_____ Name of person completing form if client is a child:_____
First Middle Last

Address:_____ City, State, Zip:_____

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

Employer/School:_____ Occupation/Grade:_____

If the client is a child, is there a legal custody agreement?_____ If yes, we will need consent of both parties as well as a copy of the most recent 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.

Who will be responsible for payment? If health insurance, is the policy in your name?_____ If no, list the policyholder's name and date of birth. Name:_____ Date of Birth:_____

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

If Medicare, list the secondary insurance information (Company, identification number, 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	___Poor sleep	___Difficulty making decisions
_____Frequent crying	_____Rapid and repeating thoughts	___Relationship issues
_____Constant worries	_____Abnormal elevated mood	___Work/career issues
_____Anxiety	_____Change in appetite or weight issues	___Anger management
_____Fear	_____Thoughts of self harm	___Trauma
_____Eating disorder	_____Thoughts of harming others	___Health concerns (describe):_

_____

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