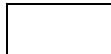




501(c) 3

GOOD SAMARITAN MINISTRIES CONFIDENTIAL CLIENT INTAKE FORM



Notice: Completion of intake paperwork does not insure that GSM will supply counseling services.

Name: _____
(Please print) (First) (Middle Initial) (Last) (marriage name changes)

Name of parent/guardian (if you are a minor): _____
(First) (Middle Initial) (Last)

Date of Birth: _____ Birth Place: _____ Age _____ Gender: Male Female

Marital status: Married Separated Divorced Partnered Never Married Single Widowed

Names and ages of children: _____

Address: _____ City _____ State _____ Zip _____

Phone: (Home) _____ (Cell) _____ (Work) _____

May we leave a message at: home phone: yes no Cell phone yes no Work phone yes no

Contact you by mail at your home address: yes no

E-mail: _____ Contact you by e-mail? yes no

Referred By: _____

If **not referred**, how did you learn about Good Samaritan Ministries? _____

Are you **currently** receiving psychiatric services or professional counseling elsewhere? yes no

If **yes**, psychiatrist or counselor's name: _____ Phone: _____

Have you seen any other Good Samaritan Ministries counselor(s) before? yes no If **yes**, list names of all counselors and approximate year(s) you were counseled: _____

Other counseling experience: yes no Who: _____ When: _____

Have you ever been diagnosed with a mental illness? yes no If **yes**, what was the diagnosis? _____

Have you ever been hospitalized because of a mental illness? yes no If **yes**, name of the hospital(s) _____ Year(s) hospitalized: _____

Are you **currently** taking prescribed psychiatric medication (antidepressants or others)? yes no

If **Yes**, please list: _____

If **No**, have you **previously** taken prescribed psychiatric medication? yes no If **Yes**, please list: _____

Primary Care Doctor: _____ Phone: _____

Other medications and dosage you are taking: _____

What type of counseling are you seeking: Individual Couple Adolescent Child Family

➔ Please turn paper over and use back of form. Incomplete paperwork will delay services. ⬅

Below line office use only

Relational Appointment Made Name of Counselor: _____ Date: _____

Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, hypertension, diabetes, etc.): _____

Do you regularly use alcohol? yes no If Yes, in a typical **month**, how often do you have **4 or more** drinks in a 24-hour period? _____

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never

If you received treatment for substance abuse, name of the facility or facilities where you were admitted and the year(s) you received substance abuse treatment: _____

Are you having any difficulty with appetite or eating habits? yes no If Yes, check below where applicable: Eating less Eating more Binging Restricting

Have you experienced significant weight change in the last 2 months? yes no _____

Do you have a history of relationship problems? yes no _____

Are you experiencing legal problems? no yes If Yes, please check all that apply: Child Custody DUI Domestic Violence Court Mandated Anger Management Other: _____

In the last year, have you experienced any significant life changes or stressors: yes no

If "Yes," briefly describe: _____

Nature of problem(s) you need help with: _____

How **motivated** are you to resolve your concerns? Not at all Mildly Moderately Highly

Are you **optimistic** that your concerns can be resolved? Not at all Mildly Moderately Highly

Employment: _____ City _____ State _____ Zip _____

Type of work: _____

Religion/Faith: Christian Jewish Muslim Buddhist Other: _____ None

Are you interested in spiritual development? yes no _____

NOTE: GSM welcomes all people in need of our services. Personal faith, if/when discussed is **by client permission only**.

In case of emergency, please notify: (someone not living at your residence)

Name: _____ Relationship to you: _____

Address: _____ City _____ State _____ Zip _____

Phone: (Home) _____ (Cell) _____ (Work) _____

GSM office where you want to receive counseling services: Beaverton Tualatin Either one

IF GSM is able to provide me with counseling services, I will commit to make every effort to be on time for available appointments and to manage my schedule to insure attendance.

I understand that not showing up for appointments may forfeit ongoing services.

GSM Offices open Monday through Thursday from 8 am to 9 pm and on Friday from 8 am to 5 pm.

PAPERWORK SHREDDED AFTER 90 DAYS FROM YOUR LAST CONTACT WITH GSM FOR SERVICES.

