

Samaritan Counseling Center of Southeast Texas Personal Information Form (Confidential)

Contact Information

Date: MM/DD/YY **Name:** LAST FIRST M.I.

Social Security Number:

Name of Parent or Guardian:(if under 18) LAST FIRST M.I.

Mailing Address: Street Name/Number

Email Address:

Telephone: Home, Work, Cell **H** **W** **C**

EMERGENCY CONTACT **PHONE NUMBER**

Employer/School:

Statistical Information:

Present Age: <input type="text"/>	Marital Status:	Ethnicity:	Who referred you to the Center?
DOB: <input type="text"/>	<input type="checkbox"/> Married	<input type="checkbox"/> White	<input type="checkbox"/> Advertizing
Gender: <input type="text"/>	<input type="checkbox"/> Single	<input type="checkbox"/> Black	<input type="checkbox"/> Clergy/Church
Are you physically challenged? <input type="text"/>	<input type="checkbox"/> Divorced	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Counselor
	<input type="checkbox"/> Separated	<input type="checkbox"/> Asian	<input type="checkbox"/> E.A.P.
	<input type="checkbox"/> Widowed	<input type="checkbox"/> Native Amer.	<input type="checkbox"/> Former Client
		<input type="checkbox"/> Other	<input type="checkbox"/> Friend/Family
			<input type="checkbox"/> Insurance
			<input type="checkbox"/> Phone Book
			<input type="checkbox"/> Physician
			<input type="checkbox"/> School
			<input type="checkbox"/> Self
			<input type="checkbox"/> Social Service Agency
			<input type="checkbox"/> Spindletop MHMR
			<input type="checkbox"/> United Way
			<input type="checkbox"/> Other
			<small>Please Specify Other</small>

Religious Preference:

Church you attend:

Financial Information:

Responsible for Payment Self Guardian Other

↓ **Annual Household Income (check one)**

<input type="checkbox"/> Up to \$10,999	<input type="checkbox"/> \$23,000 - \$26,999	<input type="checkbox"/> \$39,000 - \$42,999	<input type="checkbox"/> \$55,000 - \$58,999	<input type="checkbox"/> \$71,000 - \$74,999	Number of people in household <input type="text"/>
<input type="checkbox"/> \$11,000 - \$14,999	<input type="checkbox"/> \$27,000 - \$30,999	<input type="checkbox"/> \$43,000 - \$46,999	<input type="checkbox"/> \$59,000 - \$62,999	<input type="checkbox"/> \$75,000 - \$79,000	
<input type="checkbox"/> \$15,000 - \$18,999	<input type="checkbox"/> \$31,000 - \$34,999	<input type="checkbox"/> \$47,000 - \$50,999	<input type="checkbox"/> \$63,000 - \$66,999	<input type="checkbox"/> \$80,000 - \$85,000	
<input type="checkbox"/> \$19,000 - \$22,999	<input type="checkbox"/> \$35,000 - \$38,999	<input type="checkbox"/> \$51,000 - \$54,999	<input type="checkbox"/> \$67,000 - \$70,999	<input type="checkbox"/> Over \$85,000	

For Mental Health Insurance Coverage

Do you have your insurance Card? **Y** **N** **Member ID#**

Ins./3rd Party Payer

Name of Primary **Relationship to client**

DISCLAIMER: Verification of benefits does not guarantee claim payment. Payment for services rendered is contingent upon the participant's current benefit eligibility, available mental health benefits, medical necessity and prevailing charges. Please note that benefits can change periodically and may affect payment.

Qualifying for financial hardship. See form attached.

My fee for counseling is based on my annual household income and the number of dependents in my household or on my agreement with a third party payor. By signing the superbill I agree to pay the amount owed to the Center for counseling services.

Client/Guardian Signature: **Date:**

Counselor Signature:

Client Name: _____

The following information requested is designed to help your counselor understand you and your concerns. Please fill out this form as completely as you can. All information will be held in strict confidence.

Personal History/Information

Marital Status:
Date of present marriage
Name of Spouse: _____
Have you ever been divorced? Y N
Date of divorce _____

Education:
(indicate last grade completed - degree(s) earned)
Military Service? Y N Combat? Y N
Dates: _____

Family Background

Father's name: _____ Mother's name: _____
Living? Y N Living? Y N
Name's of brothers and sisters in order of birth: _____ Age _____ Sex _____ Deceased (Date)

Name's of children in order of birth: _____ Age _____ Sex _____ Have any children died? Y N

Medical Information

Have you had previous counseling? Y N When?
Therapist's name: _____ Are you presently seeing another therapist? Y N
Are you presently on medication? Y N Name of medication: _____
For what condition(s)? _____ Prescribed by? _____
Do you use tobacco products? Y N Have you had a physical exam in the last 3 years? Y N

How often do you consume alcoholic beverages ?
Never
Rarely
Once a week
2-3 times a week
Daily
2 or more times a day

Did/does any member of your family of origin suffer from depression, ulcers, alcohol problems, drug abuse, asthma, chronic headaches, high blood pressure, colitis, etc?
Describe: _____
Concerns:
State in your own words the concerns you bring to your counseling:

What do you believe your physical condition is at present?
Poor
Fair
Average
Good
Excellent

Check the items that describe or relate to the concerns mentioned above:

<input type="checkbox"/> Anger	<input type="checkbox"/> Suicidal Feelings
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Relationships with Parents
<input type="checkbox"/> Depression	<input type="checkbox"/> Relationships with Children
<input type="checkbox"/> Loneliness	<input type="checkbox"/> Religious Doubts
<input type="checkbox"/> Couple Relationship	<input type="checkbox"/> Loss of Faith/God
<input type="checkbox"/> Sexual Concerns	<input type="checkbox"/> Loss of Faith/Other
<input type="checkbox"/> Impotency	<input type="checkbox"/> Loss of Hope
<input type="checkbox"/> Frigidity	<input type="checkbox"/> Loss of Meaning
<input type="checkbox"/> Homosexuality	<input type="checkbox"/> Loss of Self-Respect
<input type="checkbox"/> Fear	<input type="checkbox"/> Loss of Love
<input type="checkbox"/> Self Doubt	
<input type="checkbox"/> Grief	
<input type="checkbox"/> Guilt	
<input type="checkbox"/> Other:	

What do you believe your emotional condition is at present?
Poor
Fair
Average
Good
Excellent

Additional Comments: _____

