



CLIENT REGISTRATION FORM

17195 Cleveland Road ♦ South Bend, IN 46635

Today's date:	(Please Print)	Samaritan Center ID:
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CLIENT INFORMATION

Client's last name:	First:	Middle:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one) Single / Mar / Div / Sep / Wid
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	
Is the "Primary Client" an <input type="checkbox"/> Adult <input type="checkbox"/> Adolescent <input type="checkbox"/> Child <input type="checkbox"/> Marriage <input type="checkbox"/> Family <input type="checkbox"/> Other			Client date of birth:		Age:
If client is a minor name of responsible party:			/ /		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security no.:		Home phone no.:	Ok to leave message?
				()	Yes___ No___
P.O. box:	City:	State:	ZIP Code:	Cell Phone no	Ok to leave message?
				()	Yes___ No___
Occupation:	Employer:			Work phone no.:	Ok to leave message?
				()	Yes___ No___
Referred to center by (please check one)					
<input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Pastor					
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other				Method of Payment: Client Pay <input type="checkbox"/> Insurance <input type="checkbox"/> Voucher <input type="checkbox"/> EAP <input type="checkbox"/> Client Asst. Fund <input type="checkbox"/>	
Other family members seen here:			Religious Preference/Denomination:		

GENERAL CONSENT TO COUNSELING

HIPAA: Receipt of Samaritan Family Health and Counseling Center Notice of Privacy Practices

I (print name) _____ have received a copy of the Samaritan Family Health and Counseling Center's Notice of Privacy Practices (HIPAA)

I consent to begin counseling, including evaluation, treatment and/or referral. I authorize that material from this form and future counseling sessions may be discussed with Samaritan Counseling Center staff and Center authorized professional consultants and supervisors.

I understand that this document may be scanned into a computer system or converted into electronic or digital format. I further acknowledge and agree that a copy or duplicate of this original document shall have the same force, effect and validity as the original document even though said copy or duplicate does not contain an original writing of my signature. I further acknowledge that a copy or duplicate of this document shall be deemed to be the functional equivalent of this original document for all purposes. If I checked the box that allows phone messages to be left on my mobile number I realize that cellular communications are less secure than landline phones; I absolve the Samaritan Center of any liability should anyone illegally listen into my mobile calls from the Samaritan Center.

I agree that I am responsible for the payment of all services rendered me. In the event that my insurance will not authorize payment I agree to pay for these services. I agree that I am financially responsible for failed appointments or cancelled appointments without 24 hours notice. Failure to make regular payments will initiate monthly interest charges until the account is paid. If the decision is made to turn the account over to a collection agency, I will be responsible for all resulting attorney fees and/or collection fees incurred in collecting an overdue balance. I understand that may be as much as 40% or more of my account.

I have been informed of my counselor's credential(s), degree(s) and license(s). Counselor: _____

Client or Parent/Guardian Signature

Date

Describe the Nature of the Problem You are Experiencing

Check Any of the Following That May Apply to You:

<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Indecision	<input type="checkbox"/> Shy With People
<input type="checkbox"/> Appetite increase/decrease	<input type="checkbox"/> Feel Tense	<input type="checkbox"/> Sleeping too much/not enough
<input type="checkbox"/> Use food for comfort	<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Loss of interest
<input type="checkbox"/> No Appetite	<input type="checkbox"/> Frequent Crying	<input type="checkbox"/> Loss of energy
<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Suicidal plans	<input type="checkbox"/> Sadness
<input type="checkbox"/> Passivity	<input type="checkbox"/> Fears and Phobias	<input type="checkbox"/> Home Conditions Bad
<input type="checkbox"/> Over-Eating	<input type="checkbox"/> Depressed	<input type="checkbox"/> Unable To Have A Good Time
<input type="checkbox"/> Stomach Trouble	<input type="checkbox"/> Obsessions	<input type="checkbox"/> Always Worried About Something
<input type="checkbox"/> Bowel Disturbances	<input type="checkbox"/> Too much energy	<input type="checkbox"/> Don't Like Weekends/Vacations
<input type="checkbox"/> Always Tired	<input type="checkbox"/> Take Tranquilizers	<input type="checkbox"/> Can't Make Decisions
<input type="checkbox"/> Always Sleepy	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Over-Ambitious
<input type="checkbox"/> Unable To Relax	<input type="checkbox"/> Dangerous Drugs	<input type="checkbox"/> Financial Problems
<input type="checkbox"/> Grief/loss	<input type="checkbox"/> Allergy	<input type="checkbox"/> Gambling
<input type="checkbox"/> Recurrent Dreams	<input type="checkbox"/> Asthma	<input type="checkbox"/> Job Problems
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Anger issues	<input type="checkbox"/> Can't Keep A Job
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Sexual Difficulties/Questions	<input type="checkbox"/> Verbal abuse, past or present
<input type="checkbox"/> Sexual abuse, past or present	<input type="checkbox"/> Thoughts of hurting others	<input type="checkbox"/> Plans to hurt others
<input type="checkbox"/> Others (please list):		

Physical Symptoms (Check all that apply)

<input type="checkbox"/> Tired	<input type="checkbox"/> Pain	<input type="checkbox"/> Headaches
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Stomach problems
<input type="checkbox"/> Rapid Heart Beat	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Other (please list)

Stressors you have experienced in the past two years

<input type="checkbox"/> Job loss	<input type="checkbox"/> Death of Spouse/Child	<input type="checkbox"/> Death of Close friend	<input type="checkbox"/> Job Loss	<input type="checkbox"/> New Home
<input type="checkbox"/> Divorce/Separation	<input type="checkbox"/> Job difficulties or change	<input type="checkbox"/> Financial difficulties	<input type="checkbox"/> Victim of crime	<input type="checkbox"/> Personal illness
<input type="checkbox"/> Illness in family	<input type="checkbox"/> Pregnancy in family	<input type="checkbox"/> School difficulties	<input type="checkbox"/> Work difficulties	<input type="checkbox"/> Loss pregnancy
<input type="checkbox"/> Other:				

Focus of Treatment (Check all that apply)

<input type="checkbox"/> Anger Management	<input type="checkbox"/> Anti social behavior	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Chemical dependency relapse	<input type="checkbox"/> Childhood trauma
<input type="checkbox"/> Dependency	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety and/or panic
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Family Conflict	<input type="checkbox"/> Grief/loss
<input type="checkbox"/> Relationship Conflict	<input type="checkbox"/> Financial/legal issues	<input type="checkbox"/> Medical issues
<input type="checkbox"/> Sexual abuse victim	<input type="checkbox"/> Spiritual concerns	<input type="checkbox"/> Low self esteem
<input type="checkbox"/> Paranoid thoughts	<input type="checkbox"/> Obsessive Compulsive	<input type="checkbox"/> Other:

MEDICATIONS AND SUBSTANCES USED If applicable, please list all medications you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs and supplements.

Medication	Dosage	Person prescribing	How long have you been taking this	Helpful (Y/N)

If applicable, amount of **caffeinated** beverages per day: coffee _____ soda _____ espresso _____ tea _____

If applicable, number of cigarettes smoked per day: _____ If applicable, how often do you use marijuana per week? _____

Think of the occasion that you drank the most in the **past month**. How much did you drink? ___ How many hours did you drink? ___

If applicable, other substances used _____

Do you use alcohol or drugs to (check all that apply): Manage stress?__ To relax?__ To change mood?__ For sleep?__

If applicable list any legal difficulties you have had (arrests, DUI's, etc) _____

About Yourself (check all that apply)

<input type="checkbox"/> I can accept feedback	<input type="checkbox"/> I am thinking clearly	<input type="checkbox"/> I feel confident
<input type="checkbox"/> I am motivated to change	<input type="checkbox"/> I feel confident	<input type="checkbox"/> I am capable of independent living
<input type="checkbox"/> I am reliable	<input type="checkbox"/> I live in a stable environment	<input type="checkbox"/> I am a spiritual person
<input type="checkbox"/> I often feel numb and unreal	<input type="checkbox"/> I have low self esteem	<input type="checkbox"/> My anger sometimes is out of control
<input type="checkbox"/> I am hard on myself	<input type="checkbox"/> I do things over and over	<input type="checkbox"/> I feel ineffective
<input type="checkbox"/> I am insightful	<input type="checkbox"/> I have varied interests	<input type="checkbox"/> I have a positive support network
<input type="checkbox"/> I have strong moral values	<input type="checkbox"/> I maintain good hygiene habits	<input type="checkbox"/> Other: