

Samaritan Center of Puget Sound

For Confidential Use Only

TODAY'S DATE _____ CLIENT LEGAL NAME _____

Parent/Guardian _____ Emergency Contact _____
If client is under 18 Name and phone number

BIRTH DATE _____ Occupation _____ Employer/School _____

HOME PHONE _____ Work Phone _____ Cell Phone _____
Leave Message? ___Yes ___No Leave Message? ___Yes ___No Leave Message? ___Yes ___No

ADDRESS _____
Street name and number City, State, Zip Code E-Mail Address

CURRENT COUPLE STATUS

- Never Married _____ Date(s) _____
- Married _____
- Prev. Marriage(s) # _____
- Partnered (cohabitating) _____
- Separated _____
- Divorced _____
- Widowed _____
- Engaged _____

RELIGIOUS PREFERENCE

- Christian
- Presbyterian
- Other Protestant
- Roman Catholic
- Jewish
- Muslim
- Buddhist
- Other _____
- Not Affiliated

RACE/ETHNICITY

- African American
- Asian American
- Caucasian
- Hispanic
- Native American
- Other _____

GENDER

- Female AGE _____
- Male

Name of church or place of worship: _____ # Years Education _____

GROSS ANNUAL FAMILY INCOME: \$ _____ /year Number Dependent on Income: _____

Family and Household Members (includes housemates, spouse, partner, children; continue on back if needed)

Name	Age	Sex	Relationship	Living with you?
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Physician's Name _____ Phone Number _____ Date of last exam _____

Physician's Address _____

It is our practice to coordinate care with one's physician when this would be helpful. If it is okay for us to contact your physician, please initial here: _____

Please list any surgeries or illnesses you have had the past five years: (Continue on back if needed.) _____

Please list any medications (dose) you are currently taking, or have stopped taking in the past 3 months:(Continue on back if needed.) _____

Have you had previous counseling/therapy? Yes No

If yes, when? _____ Name of Therapist(s)? _____

Reason/issue? _____

Please state your reason(s) for coming to PCS. (Continue on back if needed.) _____

Name and address of person who referred you to Samaritan _____

May we send a Thank You? (If yes, please initial.) _____ Please add me to the Samaritan mailing list. Yes No

FOR Sam USE ONLY Counselor _____ Branch _____ Fee _____ Initial Session Code _____ Case # _____

Referral Source: Return Direct Desk **File:** Ind Family **Payment:** Ins Sam/Yth EAP Self-pay **Date:** _____