the Samaritan Center
Healing - Hope - Growth

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CONFIDENTIAL

Adult Initial Questionnaire (ages 18+)

Name: _____ Date: _____

Age: _____Date of Birth: ____/____/____Gender: _____ Home Phone: (____)_____-_____

Address: _____Cell Phone: (____)_____-_____

City: _____State: _____ Zip: _____email: _____

Your occupation: _____Employer_____

Currently attend school ____Y ____N Last grade completed_____

Relationship status: Single Partnered Married Separated Divorced Widowed

Partner/Spouse's Name: _____

Do you have children? ____Y ____N If so, please list ages and gender: _____

_____

Have you ever participated in military service? ____Y ____N Combat service? ____Y ____N

How did you hear about the Samaritan Center? _____

Are you being required to seek counseling? ____Y ____N If yes, by whom? _____

Have you had other counseling or psychotherapy? ____Y ____N If yes, by whom? _____

Please list current medication: _____ Dosage: _____

medication: _____ Dosage: _____

medication: _____ Dosage: _____

medication: _____ Dosage: _____

medication: _____ Dosage: _____

medication: _____ Dosage: _____

(please continue listing medications on back of page if needed)

Current Needs/Concerns

What are your reasons for seeking counseling? _____

How long have these problems existed? _____

Since they started, have your problems: ____stayed the same? ____improved? ____Worsened?

What do you feel is the cause of your problems? _____

What personal strengths do you have that helped you cope with your problems? _____

_____

If faith or spirituality is a part of your life, do you see it as a source of strength____? Or a contributor to your stressors___? Would you like to discuss these beliefs/absence of beliefs during the course of therapy? ____Y ____N

Please check concerns that apply to you:

___ Bereavement (grief)	___ Illness of self or other person(s)	___ Addictive behavior(s)
___ Depression	___ Problems at work	___ Loss of faith in self
___ Anxiety	___ Intense anger	___ Loss of faith in others
___ Panic	___ Insecurity/self-doubt	___ Loss of hope or meaning
___ Vocational direction	___ Abuse	___ Loss of self-respect
___ Problems at school	___ Guilt	___ Loss of love
___ Nervousness or shakiness	___ Impulse control	___ Religious/Spiritual doubts or fears
___ Marriage/Partner problems	___ Unusual feelings	___ Loss of faith
___ Sexual concerns	___ Suicidal feelings or thoughts	___ Issues with sleep
___ Infidelity of self or partner	___ Relationship w/parents/in-laws	___ Troubled dreams
___ Fear	___ Relationship w/ children	___ Alcohol / Drugs
___ Disordered eating/exercise	___ Relationship w/others	___ Codependence

Other: _____

What are your goals for therapy? _____

_____

Do you believe that you can be helped? ____Y ____N

(Circle or Check)

Please rate these statements:	**Strongly Agree**	**Agree**	**Not Sure**	**Disagree**	**Strongly Disagree**
I feel good about myself:	□	□	□	□	□
I can deal with my problems:	□	□	□	□	□
I am able to maintain control in my life:	□	□	□	□	□

In the last 30 days, to what extent have the problems which lead you to seek help interfered with your:

	None	**A Little**	**Somewhat**	**A Lot**	**Extremely**
Family life	□	□	□	□	□
Social life	□	□	□	□	□
Marriage/Partnership	□	□	□	□	□
Spiritual condition	□	□	□	□	□
Emotional condition	□	□	□	□	□
Work/School/Housework	□	□	□	□	□
Health & Physical well-being	□	□	□	□	□
Physical pain	□	□	□	□	□

In the last 6 months how many times have you seen a medical professional? __Zero __1 __1-2 __4-5 __More

Do you have a serious and/or chronic medical condition? If yes, please state: _____

Are you receiving, considering filing, or have filed for disability benefits or worker's compensation? ____Y ____N

Have you consumed ___ alcohol or ___drugs in the past 30 days? Are you involved in or considering any legal action which may affect your counseling? ____Y ____N If yes, please explain _____

Thank you for completing this form. Please bring it with you to your intake session to review with your therapist.