GOOD SAMARITAN MINISTRIES PRELIMINARY APT - INDIVIDUAL

DATE: _____ ASSIGNED TO: _____
ASSESSOR: _____ DATE ASSIGNED: _____
Client Availability
Day _____ Time _____
Days _____ Hours _____ CLIENT IN CRISIS: ◯ Yes ◯ No
Referred by: _____ SUICIDAL ◯ Yes ◯ No Plan? _____
HOMICIDAL ◯ Yes ◯ No Plan? _____

GENERAL INFORMATION

Name: _____ DOB: _____ AGE: _____
Address: _____
Phone Numbers: home _____ cell _____ work _____
E-mail address: _____ Phone number we may call to leave a message _____
Employment: _____ May we contact you at work? ◯ Yes ◯ No
Marital Status: ◯ married ◯ divorced ◯ separated ◯ widowed ◯ never married ◯ other _____
Spouse (most recent): _____ DOB: _____ AGE: _____
Date married: _____ Years married: _____ Separated: _____ Divorced: _____
Spouse's Employer: _____ Phone: _____ May we contact him at work? ◯ Yes ◯ No
Previous Marriages: _____
_____
_____

Children: names, ages, where they live (other parents name if not most recent spouse)
_____
_____
_____

Client raised by birth parents? ◯ Yes ◯ No; Adoptive parents: ◯ Yes ◯ No; Step-parents ◯ Yes ◯ No; Foster parents ◯ Yes ◯ No
Support system: _____ Church family: _____

HEALTH HISTORY:

DOCTORS: Primary _____ Other Providers _____

Medical diagnosis (physical & mental) _____
_____
_____

Medicines: name, dosage, frequency (use meds chart for multiple prescription)
_____
_____

OTHER HEALTH CONCERNS: _____
_____

ADDICTION HISTORY:

□ Alcohol: last used _____ started _____ years used _____ current use _____
□ Drugs: last used _____ started _____ years used _____ current use _____
Types of drugs used _____
Other addictions _____

Treatment for addictions: _____

BIOLOGICAL FAMILY HISTORY:

Alcoholism _____ Drug abuse _____

Emotional/psychological problems _____

Health/physical problems _____

LEGAL HISTORY:

Have you ever been in trouble with the law? Yes No

Any current charges _____ Probation ends _____ Parole ends _____

Previous charges _____ Time served _____ jail prison

_____

_____

Ever had any accusation or allegation? _____

Abusive toward others _____ In what way _____

REASONS FOR COUNSELING:

_____

_____

_____

_____

_____

_____

TRAUMA HISTORY:

_____

_____

_____

_____

COUNSELING HISTORY:

Counselor's Name _____ Agency _____

Date: _____

Brief reason _____

Counselor's Name: _____ Agency _____ Date _____

Why are you not returning to a previous counselor? _____

Any additional information to help us place you with a counselor?

_____

Does client have any questions? _____

Assessor's additional comments: _____

_____

_____

_____

_____

_____

_____

In case of emergency contact: _____ Relationship _____ Phone number _____

PRINT EMAIL CLEAR