Samaritan Counseling Center
322 Old Falls Blvd, N. Tonawanda, NY 14120

Clinical Intake Information – Adult
(Please Print)

Your name: _____ Date of Birth: Client ID # _____

Why are you seeking counseling? _____

_____

_____

Check all that relate to you:

___ Grief	___ Fear	___ Loss of motivation	___ Suicidal thoughts/feelings	___ Relationship w/parents
___ Sadness	___ Anger	___ Physical abuse	___ Relationship w/ superiors	___ Religious doubts/concerns
___ Anxiety	___ Self-doubt	___ Troubled dreams	___ Marriage problems	___ Homicidal
___ Depression	___ Sexual abuse	___ Attempted suicide	___ Relationship w/ spouse	___ Other _____
___ Nervous	___Guilt	___ Loss of self-respect	___ Relationship w/ children	

Primary care physician

Name_____ Address _____ Phone _____

Date of last visit _____ on going health concerns _____

Physician Specialists

Name_____ Address _____ Phone _____

Date of last visit _____ on going health concerns _____

Name_____ Address _____ Phone _____

Date of last visit _____ on going health concerns _____

Alternative health practitioners _____ Reason for visit_____

Date of last visit _____ list Allergies _____

List medications you currently take (include vitamins and supplements) _____

_____

_____

Hospitalizations:

Date_____ Reason _____ Outcome _____

Date_____ Reason _____ Outcome _____

Date_____ Reason _____ Outcome _____