

**Samaritan Counseling Center of Southern Wisconsin
5900 Monona Drive, Suite 100 Monona WI, 53716**

NEW CLIENT INFORMATION

Please complete this form as completely as you can. All information will be held in strict confidence.

Today's Date _____

Referral

How did you learn about our services? _____

If you were referred, by whom? _____

Personal

Name _____
Last First Middle Initial

Address _____
Street and Number City State Zip

Phone (Home) _____ (Work) _____

Sex _____ Date of Birth _____ Soc. Sec. # _____

Employer _____

Employer's Address _____

Family

Married _____ Single _____ Widowed _____ Divorced _____ Separated _____

Name of Spouse _____ Date of Birth _____

(Address if different from above) _____

Spouse's Soc. Sec. # _____

Employer of Spouse _____

Employer's Address _____

Family History

All immediate family members (mother, father, siblings, partner/spouse, and children if applicable)

Name _____ Sex ____ Age _____ Lives with you ____ Lives outside of house ____
Name _____ Sex ____ Age _____ Lives with you ____ Lives outside of house ____
Name _____ Sex ____ Age _____ Lives with you ____ Lives outside of house ____
Name _____ Sex ____ Age _____ Lives with you ____ Lives outside of house ____
Name _____ Sex ____ Age _____ Lives with you ____ Lives outside of house ____

Are there any deceased children? _____

Professional

Have you had previous counseling? _____ With whom? _____

Where? _____ Why? _____

Are you currently receiving counseling, therapy, or other mental health services elsewhere?

If YES, provider's name _____ Location _____ Duration _____

Medical

Who is your Primary Medical Provider? _____

Do you have any current, recurring, or chronic medical concerns? Yes ____ No ____

If YES please describe _____

Are you presently taking medications? Yes ____ No ____

If YES please list medication and condition it is taken for:

Medication _____ Condition _____

Medication _____ Condition _____

Medication _____ Condition _____

Do you have any allergic reactions to medications? Yes ____ No ____

If YES, please describe: _____

Do you have a disability or disabilities that limit your activity in any way? Yes ____ No ____

If YES, please indicate nature of the disability: _____
