901 N. Kings Hwy., Myrtle Beach, S.C. 29577
Telephone: (843) 448-4820 / Fax: (843) 448-9875
E-mail: csccinfo@coastalsamaritan.org

Client Intake Information Form

The information requested in this form will be kept confidential, and will help your counselor assist you.

Please fill out the form as completely as you can.

GENERAL INFORMATION

Last ____________ First ____________ Middle ____________

Age ______ Date of Birth ____________ Social Security# ____________ ☐ Male ☐ Female

Street Address ____________________ City ____________

State ______ Zip ________ Phone ____________ ☐ Cell ☐ Home E-mail ____________

May we leave a message on your phone? ☐ Yes ☐ No May we contact you by e- ☐ Yes ☐ No

May we contact you by text message? ☐ Yes ☐ No

Referred By ____________ Reason for Referral ____________

Religious preference/ Congregation Name ____________ Reason for choosing CSCC ____________

RACIAL/ETHNIC IDENTITY

☐ African-American ☐ Asian-American ☐ Hispanic

☐ Native-American ☐ White/Caucasian ☐ Other

EDUCATION Highest Level of Education Completed

☐ High School ☐ Graduate Degree ☐ Other

☐ College Degree ☐ Professional Training

EMPLOYMENT ☐ Full-Time ☐ Part-Time

☐ Unemployed ☐ Stay At Home

Place of employment ____________

Type of work/position ____________

PAYMENT METHOD Do you plan to file insurance ☐ Yes ☐ No Employee Assistance Program ☐ Yes ☐ No

Do you wish to apply for fee assistance ☐ Yes ☐ No

Name of person responsible for payment ____________

FAMILY INFORMATION ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐ Cohabiting

prior marriages? ☐ Mother: age ☐ ☐ Deceased Father: age ☐ ☐ Deceased

CHILDREN				SIBLINGS			
First Name	Age	First Name	Age	First Name	Age	First Name	Age

PROBLEM DEFINITION

Reason for seeking help now? ____________________

Are any of the following conditions a problem for you at this time? (check all that apply)

☐ Anxiety	☐ Anger	☐ Substance Abuse	☐ Relationship to Parents	☐ Other (List)
☐ Grief	☐ Marriage Problems	☐ Chronic Fear	☐ Relationship to Children	
☐ Depression	☐ Sexual Problems	☐ Guilt Feelings	☐ Loss of Meaning in Life	
☐ Irrational Fears	☐ Loss of Work/Job	☐ Suicidal Feelings	☐ Loss of Faith in God	
☐ Nervousness	☐ Self Esteem	☐ Loss of Hope	☐ Conflict at Work	
☐ Loneliness	☐ Stress	☐ Rage	☐ Religious Doubts	

What would you like to see happen as a result of psychotherapy or counseling?

____

MEDICAL/PSYCHOLOGICAL HISTORY

General Practitioner/Medical Doctor Date of Last Medical Examination? ____________________

Last Name ____________________ First Name ____________________

Address ____________________

Any major surgeries, physical illnesses or mental illnesses in the last five years? ☐ Yes ☐ No If Yes, please list

Are you suffering any physical illnesses or symptoms at this time? ☐ Yes ☐ No If Yes, please list

LIST CURRENT MEDICATIONS

Medication Name	MG	Per Day	Medication Name	MG	Per Day

Have you received help for drug or alcohol dependency? ☐ Yes ☐ No

Have you received psychotherapy or counseling in the past? ☐ Yes ☐ No

Do you have thoughts of harming yourself or others? ☐ Yes ☐ No

Are thoughts of harming yourself or others a frequent occurrence? ☐ Yes ☐ No

Do you dwell on these thoughts and wonder if you can control them? ☐ Yes ☐ No

Have you sought professional help because of these thoughts and feelings? ☐ Yes ☐ No

Emergency Contact ____________________ Contact Phone # ____________________

ACKNOWLEDGEMENT: Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

Signature ____________________ Date ____________________