***Oto Serenity Concept***

**Brief Intake Schedule**

**Date:**

**Name:** **Phone**:

**Age:** **DOB:**

**Educ. History:**

**Family Information:**

**Any Drug misuse? Yes No**

**Alcohol use?** **Yes No**

**In the last two weeks, any thoughts of wanting to hurt yourself?** Yes No

**In the last two weeks have you had any thought of wanting to seriously physically hurt someone?** Yes No

**Sleep quality in the last 2 weeks: Worse Same Better**.

**Past history of psychotherapy: Yes No**.

**Medication:**

**Support system**:

**Brief reason for counseling**:

**Your Strengths:**

**Goals:**