Serenity Helping Hands Therapy Center, LLC

CLIENT INFORMATION FORM

Welcome! As part of beginning the therapy process, please take a few minutes to fill out this form. This information will help me better understand your situation and will help us both find solutions to the situations that are creating difficulties. Please note that this information is confidential.

Name of person filling out form: _____ Date: _____

Name of primary client (if different): _____

Social Security # _____ Birthdate _____

Marital Status __ S __ M __ D__ W __ ETHNICITY/ RACE: _____

Address _____

City _____ Zip _____ Email Address: _____

Mobile phone number: _____

Mobile phone messages: Okay voicemail ____Okay other person ____ No messages ____

Home phone number: _____

Home phone messages: Okay voicemail ____Okay other person ____ No messages ____

Alternate phone number: _____

Alternate phone messages: Okay voicemail ____Okay other person ____ No messages ____

May I send statements or other information to your home? Yes __ No ____

Type of services sought (Check all that apply): ☐ Individual ☐ Child/Teen ☐ Marital/Couple ☐ Family

Names of individuals living in the primary household (Please check those who will be attending counseling)

✓	First and Last Name	Relation	Birthdate	Employer / School	Position /Grade in school
		Self			

308 Gatehouse Lane ♦ Odenton, Maryland, 21113 ♦ Phone 443-214-8221 ♦ Email: aboone@serenityhhtc.com

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Sources of Stress: What are the primary issues for which you are seeking therapy?

_____
_____
_____

What are the most important things you think I should know about these issues?

_____
_____
_____

In what ways have you attempted to cope with these issues?

_____
_____
_____

Do you have any concerns or fears regarding therapy?

_____
_____
_____

What are your goals for therapy?

_____
_____
_____

Mental Health and Social History

Have you or anyone in the family attended therapy previously, or are currently in treatment? Any psychiatric hospitalizations?

☐ No ☐ Yes If yes, please indicate:

Name	Type of problem / condition	Therapist /Program	Dates of treatment

Have you or anyone in the family had suicidal thoughts / attempts / self-harm (cutting, etc.) recently or in the past?

☐ No ☐ Yes If yes, please indicate:

Name	Circumstances	Dates of treatment (if applicable)

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Have you or anyone in the family been a victim of, or perpetrator of, child abuse (physical, sexual, emotional, neglect), domestic violence, rape, or another violent act?

☐ No ☐ Yes If yes, please indicate:

Name Description of Abuse / Trauma

_____

_____

_____

Have you or anyone in the family had trouble with alcohol or other substances, now or in the past?

☐ No ☐ Yes If yes, please indicate:

Name Substance Used Frequency/Amount Still using?

_____

_____

_____

Have you or anyone in the family been involved with the legal system (probation, parole, jail, prison, DUI)? Any present or pending civil lawsuits?

☐ No ☐ Yes If yes, please indicate:

Name Reason Outcome

_____

_____

_____

Religious or spiritual preference: _____

Importance of religion to you / your family: ☐ Not important ☐ Somewhat important ☐ Very important

Were you adopted? ☐ Yes ☐ No. If yes, do you have a relationship with your biological parent(s)? ☐ Yes ☐ No

Medical History

Physician(s) currently treating self / family members:

Name of Physician Date of most recent exam Reason

_____

_____

_____

Is anyone in the family being treated for a medical problem(s) and/or disability?

Name Briefly describe

_____

_____

_____

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Current medications (for primary patient):

Name of Medication Dosage Prescribing physician Reason

_____

_____

_____

Please check any past, present, or impending issues for you or your family. Check all that apply and Circle primary concerns.

☐ Suicidal thoughts /attempts
☐ Cutting or other self-harm
☐ Depression / hopelessness
☐ Anxiety / worry
☐ Anger issues
☐ Chronic pain or illness
☐ Sleep problems
☐ Eating problems
☐ Loss /grief
☐ Legal issues
☐ Job issues /unemployed /financial
☐ Partner violence / abuse
☐ Sexual abuse /rape
☐ Alcohol / drug concerns
☐ Other addiction issues
☐ Couple concerns
☐ Marital affairs / infidelity
☐ Communication problems
☐ Sexuality / intimacy concerns
☐ Divorce adjustment
☐ Remarriage adjustment
☐ Major life changes
☐ Adjustment to divorce / remarriage
☐ School failure
☐ Truancy / runaway
☐ Fighting with peers
☐ Hyperactivity
☐ Wetting/soiling clothing or bed
☐ Isolation / withdrawal
☐ Child abuse / neglect
☐ Parent / child conflict
☐ Other:

Personal and Family Strengths and Resources Please indicate the strengths that you and others in your family have (write in names below):

Strength / Resource	Self				
Is willing to seek help					
Gets along well with other family members					
Is physically healthy					
Is generally liked and respect at work / school					
Is a hard worker					
Has family members or friends who are supportive					
Copes well with disappointment					
Uses anger constructively					
Thinks before he / she acts					
Feels good about who he / she is					
Makes friends easily and is kind to others					
Stands up for him / herself					
Follows through on tasks					
Is able to compromise					
Has a spiritual practice that helps in difficult times					

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List the people, activities, groups and hobbies that are supportive to you / your family:

_____

_____

_____

_____

Thank you for taking the time to complete this form. This information will help me to understand your situation better and will help us to reach your goals as quickly as possible. When we meet, please feel free to ask me any questions about this form, or to tell me anything else that you would like me to know.

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