SERENITY THRU STORMS – CLIENT PROFILE FORM

Client Name: _____
Date of Birth: _____
Phone Number: _____
Email Address: _____
Address: _____

Emergency Contact Information
Name: _____
Relationship: _____
Phone: _____

Service Details
What brings you to Serenity Thru Storms?
_____
_____
_____

Have you received similar support before?
■ Yes ■ No
If yes, please describe:
_____

Health & Wellness Information
Mental health diagnoses or conditions:
_____

Medications:
_____

Allergies or medical conditions:
_____

Working with other professionals:
■ Therapist ■ Social Worker ■ Support Worker ■ Doctor ■ Other: _____

Preferred Communication Method
■ Phone ■ Email ■ Text ■ Other: _____

Preferred Appointment Times:
_____

Consent to Contact
I consent to being contacted by Serenity Thru Storms regarding appointments and services.

Signature: _____ Date: _____