

SERENITY FIRST COUNSELING

CLIENT INFORMATION

Personal Information

Name: _____

Address: _____

Phone Number: _____

Email: _____

Note: Written and verbal client information supplied to us is confidential, however, we cannot guarantee the security of your email messages. Initial here to confirm that you have been informed of this. _____

Date: _____

DOB: _____ Sex: _____

May we leave a message: ___ Yes ___ No

Emergency Contact:

Name: _____

Relationship: _____

Phone Number: _____

Please briefly share what prompted you to seek counseling at this time.

Current Symptoms (Check All That Apply)

Anxiety

Depression

Panic Attacks

Guilt

Sadness or Grief

Crying Spells

Irritability

Fear

Racing Thoughts

Forgetfulness

Risky Activity

Impulsivity

Excessive Energy

Suspiciousness

Worry

Eating Issues

Isolation

Hallucinations

Sleep Changes

Libido Changes

Family History

Were you adopted? _____ If yes, what age: _____

Your Parents: Married Divorced

If Divorced – how old were you? _____

Who raised you? _____

Where did you grow up? _____

Siblings and their ages: _____

Please briefly comment on the current/past relationship (good, fair, poor, close, distant, etc.) with:

Mother: _____

Father: _____

Step-Parent: _____

Siblings: _____

Any family history of neglect, and/or physical, verbal, emotional, or sexual abuse? Yes No

Any family history of substance abuse, mental illness, suicide, or violence? Yes No

Additional Information:

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Present Situation

Work: Full-Time Part-Time Student Unemployed Disabled Retired

Which best describes your marital status?

Married, Date _____ Never Married Separated, Date _____ Divorced, Date _____
 Widowed, Date _____ Committed, Date _____ Prior Marriages _____ If so, how many? _____

What is your sexual orientation? _____

If you have children, how many and what ages are they? _____

Do you adhere to any particular religious or spiritual beliefs that you would like considered in counseling? If so, please describe. _____

Substance Abuse History (Please skip this section if there is none)

Are you currently or have you ever struggled with substance abuse? Yes No

If you answered yes, please list the types of substances:

Have you received treatment for any substance abuse issue? Yes No

If yes, please describe: _____

Health and Hobbies

Please describe any hobbies or past times in which you enjoy engaging.

Please share any health habits in which you engage or would like to engage in more (i.e. eating, exercise, meditation, etc.)

What do you hope will be different in your life as a result of your time in counseling?