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	☐ Crying Spells	☐ Risky Activity	☐ Eating Issues
☐ Depression	☐ Irritability	☐ Impulsivity	☐ Isolation
☐ Panic Attacks	☐ Fear	☐ Excessive Energy	☐ Hallucinations
☐ Guilt	☐ Racing Thoughts	☐ Suspiciousness	☐ Sleep Changes
☐ Sadness or Grief	☐ Forgetfulness	☐ Worry	☐ 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:

170 N. La Canada Dr. Suite 30C, Green Valley, AZ 85614 - fax (520) 771-8291

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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 it 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 list any medications you take regularly and for what reason:

_____

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?