Serenity Life Resource Center
Growing Community Together

INTAKE INFORMATION

Date _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Employer _____

Telephone ( )_____ Home ( ) _____ Cell ( ) _____

May I leave a message on an answering machine? ☐ Yes ☐ No

Work ( )_____ May I contact you at work? ☐ Yes ☐ No

☐ Single ☐ Married ☐ Divorced ☐ Separated

If married, date of current marriage _____

Spouse's Name _____ Date of Birth _____

Address _____

Please list additional family members living with you:

Name	Relationship	Date of Birth	Employer/School

Physician _____

Name_____

Address_____ Phone # _____

Name and phone number of relative or friend to contact in the event of an emergency

_____

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INDIVIDUAL CONCERNS

Name_____ Date_____

Please answer any of the following questions that you think apply to the reason you are seeking counseling.

Circle the following terms which pertain to you or any of your family members. Indicate concerns for yourself with a "S" and concerns for family members with an "F".

Nervousness	Health Problems	Marital Problems	Drug Usage
Shyness	Stomach Problems	Divorce	Alcohol Usage
Anger	Bowel Problems	Separation	Financial Problems
Loneliness	Depression	Affair	Problems w/Friends
Frustration	Headaches	Problems w/ ex-spouse	Can't Have Fun
Temper	Memory Loss	Stress	Tiredness
Self-Control	Sleeping Problems	Grief	Children
Insecurity	Nightmares	Parenting Problems	Career Choices
Fears	No Ambition	Relationship Problems	Problems w/Parents
Panic Attacks	Eating Problems	Legal Problems	Chronic Pain
Isolation	Suicidal Thoughts	Work Problems	School Problems
Can't Concentrate	Lack of Energy	Difficulties in Decision-making	

List any medical problems you have:

_____

_____

_____

_____

If you have noticed any <u>recent changes</u> in the following areas, <u>please circle those changes</u>

A) vision, hearing, coordination, balance, strength, speech, memory, or thinking

B) energy, sleeping, eating, elimination, menstrual cycle, or sexual activity

List all medication you are taking:

_____

_____

_____

List any other counseling you or a member of your family are receiving or have received:

_____

_____

_____

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Have you ever been physically, sexually, emotionally abused? **No** **Yes**

If yes, briefly describe: _____

_____

_____

_____

Have you ever been hospitalized for mental or nervous problems? **No** **Yes**

If yes, when and where _____

Have you ever attempted suicide? **No** **Yes**

If yes, where and when _____

_____

Are you suicidal now? **No** **Yes**

How often do you drink alcohol? _____

Have you ever been arrested for driving under the influence (DUI)? **No** **Yes**

If yes, how many times _____

Do you use drugs? **No** **Yes**

If yes, what drugs do you use and how often? _____

_____

Have you ever been arrested? **No** **Yes**

If yes, how many times and for what? _____

_____

Are you currently involved or do you expect to be involved in any court related matters? **No** **Yes**

If yes, please describe _____

_____

What is going on in your life, your marriage or family that brings you to therapy?

What kinds of stressors are you experiencing right now?

What important things about you, your marriage or family would it be helpful for your therapist to know? (i.e. illnesses, handicaps, deaths, divorces, school/job changes, suicide)