Serenity Solutions, LLC
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Intake Form

Name: _____

Address: _____

City, State and Zip Code: _____

Telephone number: _____ cell home work (circle)
_____ cell home work (circle)

E-mail address: _____

Can I contact you at the above addresses and telephone numbers and identify myself? ____Yes ____No

Can I leave a voicemail message or send a text message? ____Voicemail _____Text

Would you like to be added to Serenity Solutions' email list to receive a monthly newsletter with helpful tips, articles and information about upcoming programs? ____Yes ____No

How did you hear about Serenity Solutions?
____ Psychology Today ____ Yelp ____ HelpPro ____ TherapyTribe
____ Website ____ PSCSW ____ ThriveWorks
____ Referred by: _____ Other online listing: _____

Emergency Contact person: _____ Telephone number: _____
Relationship to you: _____

Date of Birth: _____/_____/_____ Social Security number: ____-____-_____

Gender: (circle) Male Female

Race: (circle) African American/Black American Indian/Alaska Native Asian/Asian American
Caucasian/White Hispanic/Latino Multiracial Native Hawaiian/Pacific Rim
Other _____

Religion: (circle) Agnostic/Atheist Buddhist Catholic Christian Hindi
Jewish Muslim Other _____

Sexual Orientation: (circle) Bisexual Gay Heterosexual Lesbian Questioning
Other _____

Marital Status: (circle) Single Dating Engaged Co-habitating Married
Separated Divorced Widowed Other _____

Name and Age of Partner: _____

Number of children: _____ Ages of children: _____

Employment status: (check all that apply)

____Employed ____Full-time ____Part-time ____Temporary ____Disabled
____Unemployed ____Looking ____Retired ____Never worked ____Student

Educational Level: _____

Insurance Information:

Name of Insurance: _____

Name of insured (if different from client): _____

ID#: _____ Group #: _____

Reason for Entering Therapy at this time:

_____

_____

_____

Have you been in therapy before? _____Yes _____No

Dates	Agency/Therapist/Psychiatrist	Reason for treatment

What did you find helpful about past therapy? _____

_____

What didn't you like about past therapy? _____

_____

Would you like me to request your records?

_____Yes (if yes, a release of information form will need to be signed) _____No

Symptom Checklist:
Please circle any symptom that you have now or have had in the past:

Depression	Worrying/Obsessive thoughts	Hearing voices (hallucinations)
Anger outbursts	Stress	Paranoid thoughts
Mood swings	Compulsive behaviors	Suicidal thoughts
Increased sleep	Nightmares/Flashbacks	Suicide attempts
Insomnia	Panic attacks	Cutting/self-harm
Increased appetite	Phobias	Relationship problems
Decreased appetite	Increased energy	Abuse
Poor memory	Alcohol use	Sexual difficulties
Poor concentration	Drug use	Gambling

Do you smoke cigarettes? _____Yes _____No If yes, how many per day? _____

Do you drink alcohol or use drugs? _____Yes _____No

Name of drug/alcohol	Last use	How often?	How much?

Current medical problems: _____

_____

Current medications: _____

_____

Prescribing doctor(s): (Name, address, and phone number) _____

_____

Would you like for your doctor and me to collaborate in your care?
_____Yes (if yes, a release of information form will need to be signed) _____No

Family history: Please list family members who have struggled with any of the following problems.

Medical problems: _____

Mental Health problems:_____

Drug and alcohol problems: _____

Completed by: _____

Date: _____

Revised 6/2015