SERENITY COUNSELING SERVICES

ADULT INTAKE FORM

Name: ____ **Age**: __________ **DOB**: ____________

Sex: ☐ Male ☐ Female **Race**: ________________________ **SSN**: _________________

Address (City, State and Zip):

____

____

Phone: (H) _________________ (W) ___________________ (C) ______________________

Email: ____

Relationship Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Living with someone How long? _____________

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Full-time Student

☐ Unemployed

Current Employer: ____

Insurance Details

Do you have health insurance? ☐ Yes ☐ No

Insurance Company: ____

Policy Holder Name: ____

Policy Holder Date of Birth: _________________ ID Number: ____________________________

Group Number: __________________________ Policy Holder SSN: _____________________

How were you referred for services? ____

History of Problem

Please describe the problem(s) that you want help with:

____

____

____

Medical History

Significant medical problems:

____

____

Serious illnesses, accidents, or surgeries in the past:

____

____

____

Currently prescribed medications:

____

____

History of alcohol/drug use? ☐ Yes ☐ No

Current alcohol/drug use (amount, how often, intoxication frequency):

____

Have you ever been arrested for alcohol or drug related offenses? ☐ Yes ☐ No

Have you had treatment for problems with alcohol abuse/dependency? ☐ Yes ☐ No

Have you had treatment for problems with drug abuse/dependency? ☐ Yes ☐ No

Have you ever lost a job or relationship due to the use of alcohol or drugs? ☐ Yes ☐ No

Primary Care Physician:

____

Have you ever had a mental health diagnosis? ☐ Yes ☐ No

If so, what was the diagnosis?

____

If applicable, when were you diagnosed?

____

Are you currently under psychiatric treatment? ☐ Yes ☐ No

Psychiatrist:

____

Please indicate the symptoms that you are currently experiencing or have experienced in the past year. Please indicate the severity and duration.

Severity of Symptoms				
	None 0	**Mild** 1	**Moderate** 2	**Severe** 3

Symptom	Y/N	Severity	How long?
Sadness or depression			
Suicidal thoughts			
Sleep problems			
Changes in appetite			
Weight change			
Inability to concentrate			
Obsessive thoughts			
Tension and anxiety			
Panic attacks			
Memory problems			
Compulsive behaviors			
Feelings of hostility			
Acts of violence			
Social isolation			
Strange thoughts			
Loss of interest in usual activities			
Feelings of sadness			
Feeling tired all the time			
Outbursts of anger			
Hearing voices when no one is present			

Severity of Symptoms				
	None 0	Mild 1	Moderate 2	Severe 3

Symptom	Y/N	Severity	How long?
Unable to recall some period of your day			
Walking in sleep			
Nightmares			
Overwhelming fears			
Racing thoughts			
Thoughts of harming someone else			
Feelings of being controlled by forces outside yourself			
Feeling compelled to repeat activities for no reason			
Blackouts			
Spending sprees			
Excessive sweating			
Mood swings			
Loss of sexual desire			
Periods of crying			
Feelings of hopelessness			
Other:			