MDC
SERENITY COUNSELING

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INTAKE FORM

*Your employer:*_____

*Date:*_____ *Last Name:*_____
*First Name:*_____ *Birthdate:* _____
*Age:*_____ *Address:*_____
*City/State/Zip*_____
*How long at this address:*_____

Please provide contact phone number(s) and indicate your preferred number.
*Home Phone :*_____*Leave a message? ___yes ___no preferred? ___yes ____no*
*Cell Phone:*_____ *Leave a message? ___yes ___no preferred? ___yes ____ no*
*Work Phone:*_____ *Leave a message? ___yes ___no preferred? ___yes _____no*
*Email:*_____ _____

Text messaging? ____yes ___no preferred? ___yes _____no

Referred by: _____
Do I have your permission to thank the person who referred you? _____yes ____no
*Name:*_____*Phone:*_____

☐*Married* ☐*Single* ☐*Separated* ☐*Divorced* ☐*Widowed* ☐*Committed Relationship*
☐*Living Together*

*Spouse's Name:*_____ *Birthdate:*_____*Age:*_____
*Date of current marriage:*_____
Previous marriage(s) for husband? How man y ? _____*Duration of each:*_____
Previous marriage(s) for wife? How many ? _____*Duration of each:*_____

*Names and ages of children:*_____
_____
Names and ages of prese nt household members: _____
_____

*Are there any serious medical problems or physical disabilities in your immediate family (parents, siblings, children)?*_____
_____

*Last Grade completed/degree(s)? You :*_____*Spouse:*_____
*Phone:*_____ _
*Occupation :*_____*Length of time on job:*_____
*Spouse's employer:*_____*Phone:*_____
*Occupation :*_____*Length of time on job:*_____
Nearest relative not living with you: _____*Phone:*_____

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(continued)

Whom may we contact in case of an emergency who does not reside with you?

_____ *Phone:*_____

*Briefly, how would you describe the situation or problem that brings you here:*_____
_____
_____
_____

*Are you taking any medications? If yes, what, how much, and with what results:*_____
_____
_____

What actions, if any, have you taken toward finding a solution?

_____
_____

Role of religion and/or spirituality in your life:

In childhood: _____
As an adult: _____

*Present interests, hobbies and activities:*_____
_____

*How do you spend most of your free time?*_____
_____

Have you or any other family member ever received prior counseling or treatment?
☐ *Yes* ☐ *No*

*If yes, whom and when?*_____
*What do you expect from therapy and how long do you expect therapy to last?*_____
_____
_____

*What is there about your present behavior that you would like to change?*_____
_____
_____

*In a few words, what do you think therapy is all about?*_____
_____
_____

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(continued)

Presenting problems: *(check all that apply in attending couples counseling please put your initials next*

to the problems that apply)
___*very happy*
___*irritable*
___*temper out bursts*
___*withdrawn*
___*daydreaming*
___*fearful*
___*worry*
___*overactive*
___*slow*
___*short attention span*
___*distractible*
___*lacks initiative*
___*undependable*
___*social problems*
___*crying spells*
___*hairpulling*
___*impulsive*
___*stubborn*
___*panic attacks*
___*lying*
___*mean to others*
___*destructive*
___*trouble with the law*
___*health problems*
___*self mutilating*
___*stressed out*
___*relationship problems*
___*shy*
___*strange behavior*
___*strange thoughts*
___*physical abuse*
___*sexual abuse*
___*parenting problems*
___*stealing*
___*repetitive/ritualistic behaviors*
___ *grief*
___*employment problems*
___*financial stress*
___*legal prob lems*
___*violence*
___*eating problems*
___*sleeping problems*
___*sexual problems*
___*drug use*
___*alcohol use*
___*suicidal thoughts*
___*homicidal thoughts*

Explain:

_____

_____

_____

_____

What are your goals for treatment?

_____

_____

_____

_____

Is there anything else you feel is important for your therapist to know?

_____

_____

_____

_____

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STATE OF KANSAS PHYSICIAN CONSULT

I understand that when I describe symptoms that may be consistent with a mental disorder, these symptoms can have medical or biological origins and that my therapist must consult with my physician, unless I waive this requirement.

☐ *No, I do not want my therapist to contact my physician and I waive this requirement. (Please sign below.)*

_____ _____

Client Signature *Date*

☐ *Yes, I request that my therapist consult with my physician regarding my mental health. (Please sign below.)*

_____ _____

Client Signature *Date*

Physician's Name: _____
Address: _____
Phone Number: _____

_____ _____

Client Signature *Date*

_____ _____

Witness Signature *Date*