Serenity Insight

New Client Information

Name:	Date of Birth:	Age:	Gender:
Street Address:	City:	State:	Zip Code:
May we contact you at this address? ☐ Yes ☐ No			
Contact Number:	May we contact you at this number? ☐ Yes ☐ No		
Email Address:	May we email you? ☐ Yes ☐ No		
Marital/relationship status:	Ethnic/Cultural Background:		
Highest Level of Education:	Occupation:		

Referral Information

How did you hear about Serenity Insight?

☐ Google/Internet Search
☐ Goodtherapy.org
☐ Insurance Listing
☐ Psychologytoday.com
☐ Openpathcollective.org
☐ Other (Please Provide Details):

Were you referred by a specific person or agency? ☐ Yes ☐ No
Referred By:

Primary Insurance Information

Insurance Company:	Policy Owner's Name:
Policy Owners Date of Birth:	Policy Owner's SSN:
Insurance ID#:	Policy Owner's Address:
Do you have secondary insurance? ☐ Yes ☐ No	

Please be prepared to provide our office staff with your insurance card and photo ID so that we may make a copy.

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Emergency Contact

Name:	Contact Number:	Relationship:

Current Concerns

What are your areas of concern that bring you to counseling? _____ _____ _____ _____
How has this affected your life? ☐ Lifestyle ☐ Relationships ☐ Sleeping ☐ Activities ☐ Mood

Have you ever attempted suicide? ☐ Yes ☐ No If yes, when?
Are you currently thinking about suicide? ☐ Yes ☐ No
Have you ever thought about harming/killing someone else? ☐ Yes ☐ No If yes, when?
Are you currently thinking about harming or killing some else? ☐ Yes ☐ No
Do you use alcohol or drugs? ☐ Yes ☐ No If yes, what type and how often?
Have you ever received treatment for substance abuse ☐ Yes ☐ No
Are you currently being treated by another mental health professional ☐ Yes ☐ No
Are you currently under the care of a physician? ☐ Yes ☐ No
Are you currently using any medication? ☐ Yes ☐ No If yes, what type?

Client Signature:	Date:
Parent/Guardian Signature:	Date:
Counselor Signature:	Date: