The Serenity Center, Inc.

Adult Client Questionnaire (Client ages 18 and over)

To be completed by the client requesting services.

This, as well as other communications with your therapist, will be kept confidential to the full extent of Georgia law.

Identifying Information: Date:_____

Name:_____DOB:_____Age:_____

Home Address:_____
City, State, Zip

Cell/Home Phone:_____ Work Phone:_____

May we leave a message at this number? Y * N Can you be contacted at work? Y * N

Email: _____

Can we use your email to send appointment reminders? Y * N

Employer:_____Occupation:_____

Marital Status: Single * Married (circle one)

If Divorced, for how long:_____ _Number of Marriages:_____

Primary Physician or other health care provider:_____

Telephone:_____

Billing Information:

Party Responsible for Payment:_____ Relation to Client:_____

Insurance Information:	PRIMARY	SECONDARY
Insurance Company	_____	_____
Policy Holder's Name	_____	_____
ID Number	_____	_____
Employer	_____	_____
Group Number or Name	_____	_____

Family Information: Name Age Living with You?

Spouse/Partner _____ _____ Y or N

Children _____ _____ Y or N

_____ _____ Y or N

Others living with you:_____

Education:_____

Religious affiliation:_____Active_____Inactive_____

How significant is religion to your everyday life?_____

Military Service:_____

List any medications you take – prescription or over the counter:_____

The following is a list of problems people commonly have. Read each one carefully and circle the number to the right that best describes how much that problem is of concern to you.

0 – Not at all 1 – Mildly 2 – Moderately 3 – Very Much 4 – Extremely

1_ Feeling low in energy or slowed down	0	1	2	3	4
2_ Dissatisfied with my spiritual life	0	1	2	3	4
3_ Repeated, unwanted thoughts that won't leave my mind	0	1	2	3	4
4_ Loss of control, or fear of losing control of my temper	0	1	2	3	4
5_ Not satisfied with my weight or appearance	0	1	2	3	4
6_ Nervousness or shakiness inside	0	1	2	3	4
7_ Troubled by sexual thoughts or behavior	0	1	2	3	4
8_ Drink when troubled or under pressure	0	1	2	3	4
9_ Unusual fears that most people don't have	0	1	2	3	4
10_Thoughts of ending my life	0	1	2	3	4
11_Sleep that is restless or disturbed	0	1	2	3	4
12_Problems with police or legal matters	0	1	2	3	4

13_Feel withdrawn and/or isolated	0	1	2	3	4	
14_Loss/absence of sexual desire or pleasure		0	1	2	3	4
15_Other people being aware of my private thoughts	0	1	2	3	4	
16_Feeling hopeless about the future	0	1	2	3	4	
17_Problems with my eating	0	1	2	3	4	
18_Spells of terror or panic	0	1	2	3	4	
19_Feeling shy or uneasy with the opposite sex	0	1	2	3	4	
20_Drinking or emotional problem in my family	0	1	2	3	4	
21_Feeling that others are watching or talking about me	0	1	2	3	4	
22_Things about my life that are too painful to talk about	0	1	2	3	4	
23_Difficulty feeling close to another person		0	1	2	3	4
24_Problems dealing with stress or anxiety	0	1	2	3	4	
25_Sadness or tearfulness	0	1	2	3	4	

Why did you decide to seek counseling time?_____
_____

How long do you expect your therapy to last?_____
_____

Have you ever received counseling before? If so, when, why, and with whom?_____
_____

What goals do you hope to accomplish by participating in therapy?_____
_____

Is there anything else which you believe or feel might be important to know about?
_____

Authorization for treatment:

I authorize treatment to be administered by The Serenity Center, Inc.

Client Signature:_____Date:_____