Serene Pathways Counseling, LLC

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All submitted information is confidential. If an item does not apply to you write "NA".

Adult History: Today's Date: ___________________

Name:____ Date of Birth: _______________________________

Place of Birth:_______________________________________ Female: _____Male:_______

Current Address:________________________________City::________________________State:_____Zip:_________

Best phone number(s) to reach you at: ____

Home Phone:____________________ Cell Phone: ________________Work Phone:______________________

Please describe the reason for your appointment: ____

____

____

Hobbies/Interests: ____

____

Describe yourself in 3 to 5 words: ____

Family Composition:

_____ Married _____ Divorced _____ Never Married _____ Single _____ Single with Partner _____ Widowed

Name of Spouse or partner? (optional)____

Children/Grandchildren _____Yes_____ No

If so, please list names and ages below (optional):

_______________________ _______ _______________________ _______ ______________________ _______

_______________________ _______ _______________________ _______ ______________________ _______

_______________________ _______ _______________________ _______ ______________________ _______

Optional Information:

Race and Ethnicity:____

Religious Affiliation: ____

Is there anything that may interfere with counseling? ____

Medical Information:

PrimaryCarePhysician:________________________________ Phone number:_______________________

Date of Last Physical: ____________________

Physical Concerns: (Please check any that apply)

_____ Depression _______ Anxiety ________ Stress

_____Headaches _______Sleep problems _______Stomach problems

_____Other____

____

List any current medication, dosage, and reason for usage (including vitamins/herbs/over the counter medication): ____

____

Other Concerns: (Please check any that apply)

_____ Nightmares ______ Family Problems _______ Problems with Child(ren)

_____ Fear ______ Relationship Problems _______ Custody Problems

_____ Anger ______ Suicidal thoughts or actions _______ Domestic Violence

_____ Other

____

____

Symptoms:

In the last 3 to 6 months have you had any of the following symptoms that have lasted for more than a few weeks:

_____ mental confusion

_____ frequent arguments

_____ nervous habits/behavior

_____ grinds teeth

_____ hyperactivity

_____ too interested in sex

_____ little or no interest in sex

_____ difficulty concentrating

_____ seeing things not there

______ tire quickly/easily

______ little interest in activities

______ worries a lot

______ afraid/fearful

______ short attention span

______ I am disorganized

______ cry frequently

______think too much about my problems

______ feel stressed at work

______ hearing voices

______ concerned about the future

______ feel lonely

______ feel hopelessness

______ keep to myself most of the time

Have you been or are you currently under the care of another mental health professional (i.e. psychiatrist, psychologist)? _____Yes _____No

If yes, please explain: ____

____

Do you or any family members have any history of depression or other similar problems (i.e. anxiety, manic depression, schizophrenia)? Yes _______No______

If yes, please explain:

____

____

Do you or your family have any history of drug/alcohol abuse? _______ Yes _______ No

If yes, please explain: ____

____

Is there a history of any type of abuse towards you or around you? ________Yes _______ No

If yes, please explain: ____

____

Legal Involvement:

Is or was there ever any court involvement? ______ Yes ______ No

Please explain: ____

____

____

Employment:

Are you currently employed? Yes_________ No__________

Part-Time_____ Full-Time_____ Stay-at-home Parent_______ Student ______ Retired_______ Other___________

Employer: _____________________________________ Position: __________________________ Length: ________________

How would you describe your current work situation: ____

____

Responsible Party/Insurance information

Responsible party if minor, etc: ____

Responsible party phone number: __________________________

__________ I give my consent for this office to discuss my financial account with the above party **(must have for clients over 18 and dependent upon parent's insurance, etc)**

Primary Insurance information (please present card)

Insurance:____Employer____

Subscriber or enrollee ID number: ____

Policy holder's name: ____DOB: ______________________________

Secondary Insurance information (please present card)

Insurance: ____Employer: ____

Subscriber or enrollee ID number: ____

Policy holder's name: ____DOB: ______________________________________

Communication by Email/Texting

_____ I disagree with sending or receiving communication through either of these forms of communication.

_____ I agree with sending or receiving communication through the following:

_____ Email- address is: ____

_____ Text- phone number is: ____

Notice of Privacy Practices Receipt and Acknowledgment

I, the undersigned, hereby acknowledge receipt of the Notice of Privacy Practices given to me by Serene Pathways Counseling, LLC.

Cancellation Policy

I, the undersigned, understand that the therapists of Serene Pathways Counseling respect my time and ask that I respect theirs as well. I understand that if I cannot give 24 hours' notice of a cancellation that I may be charged a $35 fee which is payable prior to resuming counseling services. This fee is not billable to my insurance company (third party payer)

Financial Responsibility

I, the undersigned, hereby authorize release of information necessary for SPC to file a claim with my insurance company (third party payer) and assign benefits otherwise payable to me to the provider or group indicated on the claim. I understand that I am financially responsible for any balance not covered by the third party payer, i.e. co-payments, co-insurance, deductibles or non-covered services.

Consent to Treat

I verify that the information given is correct and I consent to receiving therapy services.

____Date________________

Signature of Client

____Date_________________

Signature of Staff Member