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Intake Form

Name: _____

Address: _____

City, State and Zip Code: _____

Telephone number: (home) _____
(work) _____
(cell) _____

Can I contact you at the above addresses and telephone numbers and identify myself? ____ Yes ____ No
Limitations: _____

E-mail address: _____

Would you like to be added to Serenity Solutions' email list? ____ Yes ____ No

How did you hear about Serenity Solutions?

____ Website
____ Psychology Today
____ Google/Yahoo search
____ Other website: _____
____ Referred by: _____
____ Other: _____

Emergency Contact person: _____ Telephone number: _____
Relationship to you: _____

Date of Birth: ____/____/____

Social Security number: ____ - ____ - _____

Gender: (circle) Male Female

Race: (circle) African American/Black American Indian/Alaska Native Asian/Asian American
Caucasian/White Hispanic/Latino Multiracial Native Hawaiian/Pacific Rim
Other _____

Religion: (circle) Agnostic/Atheist Buddhist Catholic Christian Hindi
Jewish Muslim Other _____

Sexual Orientation: (circle) Bisexual Gay Heterosexual Lesbian Questioning
 Other _____

Marital Status: (circle) Single Dating Engaged Co-habiting Married
 Separated Divorced Widowed Other _____

Name and Age of Partner: _____

Number of children: _____ Ages of children: _____

Employment status: (check all that apply)

Employed Full-time Part-time Temporary Disabled
 Unemployed Looking Retired Never worked Student

Educational Level: _____

Insurance Information:

Name of Insurance: _____

ID#: _____

Group #: _____

Address and Phone number: _____

Reason for Entering Therapy at this time:

Have you been in therapy before? Yes No

If yes:

Dates	Agency/Therapist/Psychiatrist	Reason for treatment

What did you find helpful about past therapy? _____

What didn't you like about past therapy? _____

Would you like me to request your records?
_____ Yes (if yes, a release of information form will need to be signed) _____ No

Symptom Checklist:

Please circle any symptom that you have now or have had in the past:

- | | | |
|--------------------|-----------------------------|---------------------------------|
| Depression | Worrying/Obsessive thoughts | Hearing voices (hallucinations) |
| Anger outbursts | Stress | Paranoid thoughts |
| Mood swings | Compulsive behaviors | Suicidal thoughts |
| Increased sleep | Nightmares/Flashbacks | Suicide attempts |
| Insomnia | Panic attacks | Cutting/self-harm |
| Increased appetite | Phobias | Relationship problems |
| Decreased appetite | Increased energy | Abuse |
| Poor memory | Alcohol use | Sexual difficulties |
| Poor concentration | Drug use | |

Current medical problems: _____

Current medications: _____

Prescribing doctor(s): (Name, address, and phone number) _____

Would you like for your doctor and me to collaborate in your care?
_____ Yes (if yes, a release of information form will need to be signed) _____ No

Do you smoke cigarettes? ____ Yes ____ No If yes, how many per day? _____

Do you drink alcohol or use drugs? ____ Yes ____ No

If yes:

Name of drug/alcohol	Last use	How often?	How much?

Completed by: _____

Date: _____