

Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.

Please note: information provided on this form is protected as confidential information.

Personal Information

Name: _____ Date: _____

Parent/Legal Guardian (if under 18): _____

If yes, please explain: _____

Address: _____

Home Phone: _____ May we leave a message? Yes No

Cell/Work/Other Phone: _____ May we leave a message? Yes No

Email: _____ May we leave a message? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

DOB: _____ Age: _____ Gender: _____

Marital Status:

Never Married Domestic Partnership Married

Separated Divorced Widowed

Referred By (if any): _____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? Yes No

If yes, please list:

Have you ever been prescribed psychiatric medication? Yes No

If yes, please list and provide dates:

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

2. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems: _____

5. Are you currently experiencing overwhelming sadness, grief or depression? No Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? No Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? No Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? No Yes

9. How often do you engage in recreational drug use?

Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? No Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

11. What significant life changes or stressful events have you experienced recently? _____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

Additional Information

1. Are you currently employed? No Yes

If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work? _____

2. Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief: _____

3. What do you consider to be some of your strengths? _____

4. What do you consider to be some of your weaknesses? _____

5. What would you like to accomplish out of your time in therapy? _____

CLIENT ID# _____

Disclosure Statement

Janean Byrne, MS, LMHC

Training and professional background:

Janean Byrne earned her master's degree at Hodges University. She is a Licensed Mental Health Counselor in the state of Florida #MH15525. Janean's clinical experience and Interest has been working with Women and Women's Issues, Men's issues, Children and Couples. In Therapy, her focus has been on Anxiety, Depression, Post-Traumatic Stress Disorder, CoDependency, Relationships, Self-Esteem, Boundaries, Focus Concerns, Grief and Self-Confidence, as well as many other hindrances that inhibit us from reaching our best potential and enjoying life. She specializes in relationship concerns, anxiety, grief, depression and focus concerns. She believes in taking a holistic approach to therapy, while considering an individual's health, sleep patterns, spirituality, relationship dynamics, etc.

The rights of clients in counseling:

It is appropriate for clients to raise questions about the counselor, the therapeutic approach, the progress of the therapy and the cost. As informed consumers, it is the client's responsibility to choose the counselor and counseling modality which best suits their needs. Clients have the right to request a change in counseling approach, referral to another counselor or termination at any time.

Janean Byrne is bound by the ethical codes of her respective professional organizations, by the laws of the State of Florida, as well as by agency policy regarding the special nature of the therapist-client relationship. It is expected that the counselor will continue to be aware of the influential position they hold in the relationship with clients, using this influence in a constructive way. If a client thinks his/her counselor is not meeting this ethical responsibility, he/she is strongly encouraged to address this with the counselor.

Confidentiality:

Counseling sessions are held in strict confidence. It is the client, not the therapist, who determines whether information may be released to persons outside of this office, and only then, with a release signed by the client. The counselor may be required to break confidentiality in life-threatening situations where the client poses a clear and present danger to self or others or is unable to provide minimum life sustaining self-care. In these situations, the counselor is required to take steps necessary to secure the safety of the client or others.

My signature below acknowledges that I am the legal guardian of _____ and have received and understand the Disclosure Statement; thus, consenting to their participation in counseling services at Serenity Counseling Center.

Client (or legal guardian's) signature(s) _____ Date _____

Client Signature _____ Date _____

Mental Health Counselor Signature _____ Date _____

Serenity Counseling Center

Patient Treatment Agreement

Welcome to Serenity Counseling Center. We would like to ensure you that you will receive the best possible care from our professional staff.

Payment: Due at the time that the service is provided. We accept credit or debit cards. A 3% fee will be applied to credit or debit transactions. The fee for a 50-minute session is \$90.00. As a client, you are agreeing to pay \$90 at the end of each session.

Cancelations: If you are unable to keep your scheduled appointment, you must notify your counselor 24 hours prior to your appointment or you will be charged a \$50.00 cancellation fee. You are giving Serenity Counseling Center permission to contact you via phone call, text or email concerning your appointment, case information or other business pertaining to Serenity Counseling Center.

Legal: Our counselors are available for in-office depositions at an agreed upon fee. The counselors are not available, nor will appear in court for testimony regarding a case unless arrangements are made outside of and prior to this initial agreement. By signing you agree that this information has been formally conveyed.

“I, the undersigned, agree to treatment by the providers in this office, and furthermore have read and understand the above policies”.

Client Name: _____ Date: _____

Client Signature: _____ Date: _____