



*Restoring Hope, Health, and Serenity*

## *Serenity Point Counseling*

312 Chestnut Street Suite 113

Meadville, PA 16335

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### CLIENT APPLICATION FORM

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Preferred Phone # \_\_\_\_\_ Emergency # \_\_\_\_\_

S.S. # \_\_\_\_\_ Email Address \_\_\_\_\_

### PERSONAL INFORMATION

What is the problem, chief complaint, or concern that led you to seek counseling?

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Please check all that you feel apply to yourself:

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|--|---|--|
| <input type="checkbox"/> anxiety             | <input type="checkbox"/> depression           | <input type="checkbox"/> drug/alcohol addiction          |
| <input type="checkbox"/> self-harm           | <input type="checkbox"/> mental health issues | <input type="checkbox"/> spiritual confusion or concerns |
| <input type="checkbox"/> compulsions         | <input type="checkbox"/> eating disorder      | <input type="checkbox"/> relational/marital difficulties |
| <input type="checkbox"/> mania               | <input type="checkbox"/> grief issues         | <input type="checkbox"/> post-traumatic stress           |
| <input type="checkbox"/> sexual abuse issues | <input type="checkbox"/> rape                 | <input type="checkbox"/> domestic violence issues        |
| <input type="checkbox"/> anger issues        | <input type="checkbox"/> war veteran          | <input type="checkbox"/> other _____                     |

What is your current marital status? \_\_\_\_\_ married \_\_\_\_\_ divorced \_\_\_\_\_ separated \_\_\_\_\_ single

How many children do you have? \_\_\_\_\_ Boys \_\_\_\_\_ Girls \_\_\_\_\_ None

What are their ages? \_\_\_\_\_

What relational conflicts do you currently have with spouse or children?

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Who would you consider to be a main support to you?

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**Other Questions**

What changes do you hope your therapy will lead to?

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How can I assist you to make these changes?

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If you could meet one goal what would it be?

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How motivated to change are you?

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Circle what you consider to be your major **strengths/assets**:

accepts guidance/feedback; capable of Independence; clear thinking; confident; expressive/articulate;  
good personal care habits; insightful; integrated moral values; intelligent; motivated for change;  
physically healthy; positive support network; reasonable judgment; reliable; responsible; sociable;  
stable living environment; stable work history; supportive family; varied interests;  
other \_\_\_\_\_

Circle what you consider to be you **major weaknesses**:

chaotic living; concrete thinking; defensive; dependent; distrustful; hostile; illiterate; impulsive;  
indecisive; intellectual deficits; irresponsible; lacks insight; lacks moral/ethical values; needs close  
supervision; negative peer group; no support network; non-supportive family; not motivated to  
change; not open/articulate; poor health; poor hygiene/grooming; poor judgment; unreliable;  
unstable employment history; very narrow interests; other \_\_\_\_\_

**Recreational History**

When are you happy? What are some positive factors in your life? Hobbies, interests, or leisure activities?

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What would you say are your major coping mechanisms? (what you do to handle stress)

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What are your defense mechanisms? (what you do to protect myself i.e. shut down, avoidance, etc.)

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**Education**

How did you fare academically in grade school and high school?

\_\_\_\_\_  
Please list your highest level of education (i.e. high school, college, technical school)

\_\_\_\_\_  
Please circle how you would describe your intelligence: Below Average / Average / Above Average

**Employment**

Are you currently employed? \_\_\_\_\_ Where? \_\_\_\_\_ Position? \_\_\_\_\_

What types of job have you held? Where, when and why did you leave?

\_\_\_\_\_  
My last employment was where and for how long?

\_\_\_\_\_  
My current financial stressors are:

**Socio-Economic History**

How would you describe your family's socio-economic status? (i.e. poor, middles class, well-off)

\_\_\_\_\_  
What is your current living situation? (who you live with in an apartment, house, etc.)

**Military**

Did you serve in the military? \_\_\_\_\_ If yes, when, what branch, and for how long?

\_\_\_\_\_  
Were you involved in combat? \_\_\_\_\_

Type of Discharge: \_\_\_\_\_

**Substance Abuse History**

Please list the people in your immediate family and extended family that use or used drugs or alcohol:

\_\_\_\_\_  
Describe your current drug/alcohol usage/drug of choice:

I am currently using: \_\_\_\_\_

Frequency of use? \_\_\_\_\_

The last time I used was:

When? \_\_\_\_\_ Substance? \_\_\_\_\_ How much? \_\_\_\_\_

My longest clean time was:

How long ago? \_\_\_\_\_ Duration? \_\_\_\_\_

Please list any consequences you have suffered as the result of substance/alcohol abuse:

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Do you gamble? \_\_\_\_\_ If so, how often? \_\_\_\_\_

What type of gambling are you involved in? \_\_\_\_\_

How much loss do you incur? Weekly \_\_\_\_\_ monthly \_\_\_\_\_

Has gambling caused financial problems or consequences? If so what are they?

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### **Legal History**

Describe your legal history past and current.

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Do you have any charges pending? \_\_\_\_\_ If yes, what are the charges? \_\_\_\_\_

\_\_\_\_\_ THC \_\_\_\_\_ BAC \_\_\_\_\_

Have you served time in jail? \_\_\_\_\_ If yes, for what? \_\_\_\_\_

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Describe any current probation/electronic monitoring: \_\_\_\_\_

Who is your probation officer and what is their phone number?

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I am currently in litigation in a civil case: Yes or No (circle one)

### **Psychiatric Information**

Describe previous mental health episodes and treatments. Please list dates and location.

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What type of treatment did you have (i.e. group, individual, psychiatric) and what was the outcome (i.e. it helped/did not help, helped somewhat, etc.)?

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Are you undergoing psychiatric care? \_\_\_\_\_ If yes, with whom? \_\_\_\_\_

List any psychiatric medications and dosage that you currently take and the doctor who prescribed them:

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**Medical Information**

Do you have any current health problems? \_\_\_\_\_ If yes, check those that apply:

- |                          |                        |                         |
|--------------------------|------------------------|-------------------------|
| ____ physical injuries   | ____ chronic illnesses | ____ allergies          |
| ____ eating difficulties | ____ lack of exercise  | ____ sleep disturbances |
| ____ sexual dysfunction  | ____ chronic pain      | ____ obesity            |
| ____ underweight         | ____ cancer            | ____ other _____        |

List any medication you take for physical health issues, the dosage and specific instructions:

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When was your last exam by a medical doctor? \_\_\_\_\_

**Sexual History**

Sexual Preference: \_\_\_\_\_ Age of first sexual encounter \_\_\_\_\_

Describe any sexual dysfunction:

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Describe any past/present sexual abuse/issues:

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**Family Information**

My parents' marital status is \_\_\_\_\_ married \_\_\_\_\_ divorced \_\_\_\_\_ separated \_\_\_\_\_ single

My parents' current age and health status:

Mother \_\_\_\_\_

Father \_\_\_\_\_

My parents' education level:

Father \_\_\_\_\_

Mother \_\_\_\_\_

How many brothers/sisters do you have and what are their ages? Current health status?

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How would you describe your childhood?

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**Developmental History**

Did you suffer any traumatic events in childhood? Check those that apply.

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|--|--|
| <input type="checkbox"/> death of parent/sibling       | <input type="checkbox"/> sexual abuse                        |
| <input type="checkbox"/> mental abuse                  | <input type="checkbox"/> physical abuse                      |
| <input type="checkbox"/> severe accident in family     | <input type="checkbox"/> foster care                         |
| <input type="checkbox"/> juvenile detention center     | <input type="checkbox"/> mental health issues                |
| <input type="checkbox"/> drug or alcohol abuse in home | <input type="checkbox"/> head or brain trauma                |
| <input type="checkbox"/> moving from house to house    | <input type="checkbox"/> poverty                             |
| <input type="checkbox"/> family illnesses              | <input type="checkbox"/> was told I was a difficult delivery |
| <input type="checkbox"/> early parental separation     | <input type="checkbox"/> other: _____                        |

List any mental health or addiction issues you had during childhood:

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List any physical handicaps or severe illnesses you had in childhood:

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Did you consider yourself relational or a loner, active or quiet when you were growing up?

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**Spiritual Development**

Do you have a faith background? Please describe:

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What spiritual or religious issues are important to you?

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Any other relevant information you would like therapist to know: \_\_\_\_\_

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Client Signature \_\_\_\_\_ (date) \_\_\_\_\_

Therapist Review \_\_\_\_\_ (date) \_\_\_\_\_