Serenity in Motion
Counseling Services

Client 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 and personal information.

Personal Information:

Client Name: _____ Date: _____/_____/_____

Parent/Legal Guardian (if under 18): _____

Mailing Address: _____
Street City State Zip

Physical Address: _____
Street City State Zip

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

Cell Phone: _____-_____-_____ May we leave a message? Yes No
May we text? Yes No

Email: _____ May we email? Yes No

Date of Birth: _____ Age: _____ Sex: _____ Race: _____

Religion/Spiritual Alliance: _____

Marital Status: ☐ SINGLE ☐ INTIMATE PARTNER ☐ DOMESTIC PARTNERSHIP ☐ MARRIED
☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

Referred By (if any): _____

501 East Front Street, Suite 513, Butte, MT 59701
406.565.5154 ph 406.565.5040 fax
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Presenting Problem(s):

Presenting Problem(s) (what is causing you distress?): _____

_____

Symptoms (how do you know when you are in distress?): _____

_____

Onset (when did your symptoms begin?): _____

_____

Duration (how long do your symptoms last?): _____

_____

Frequency (how often are symptoms present): _____

_____

Psychiatric History:

Psychiatric Care Provider (DO, MD, NP, PA):
- Who: _____
- Where: _____
- Address: _____
- Phone: _____
- Fax: _____

Prior Out-Patient Treatment:
- Who: _____
- Where: _____
- When: _____
- What symptoms: _____
- What diagnoses: _____

Prior In-Patient History:
- What in-patient institution(s): _____
- Where: _____
- When: _____
- What symptoms: _____
- What diagnoses: _____

Self-Harming Behaviors:
- Method: _____
- Where: _____

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First/Last incident: _____
Contributing factors: _____
Suicide Attempts:
Method: _____
When: _____
Contributing factors: _____

Trauma History:

Nature of trauma: _____
When occurred: _____
Persons involved: _____

Family Psychiatric History:

History of mental illness in the family:
Who: _____
Diagnoses: _____
In/Out-Patient Services: _____

Medical Conditions & History:

Primary Care Provider (DO, MD, NP, PA):
Who: _____
Where: _____
Address: _____
Phone: _____
Fax: _____
Current Medical Conditions: _____
Treatments: _____
_____
Past Medical Conditions: _____
Treatments: _____
_____
Past Surgeries: _____
_____
Allergies: _____

Current Medications:

Medication(s): _____
Dosage(s): _____
Purpose: _____
Prescriber: _____

Substance Use History:

Type of Substance	Age of first use	Age of last use	Amount	Frequency	Method of use	Treatment
☐ Alcohol						
☐ Amphetamines						
☐ Benzodiazepines						
☐ Cannabis/Hash						
☐ Cocaine/Crack						
☐ Ecstasy/Molly						
☐ Hallucinogens						
☐ Hashish						
☐ Heroin						
☐ Inhalants						
☐ Methadone						
☐Methamphetamine						
☐ Opiates						
☐ PCP						
☐ Suboxone						
☐ Synthetic drugs (spice, bath salts, salvia, etc.)						

Family History:

Family of origin:

Father: _____ Present during childhood? Yes No
Mother: _____ Present during childhood? Yes No
Brother(s): _____ Present during childhood? Yes No
Specify #: _____
Sister(s): _____ Present during childhood? Yes No
Specify: _____
Relationship to family of origin: _____
_____

Current family:

Spouse (Name, Age): _____
Children (Name(s), Age(s)): _____
Relationship to family: _____
_____

Social History:

Significant relationships: _____
_____
Social supports: _____
_____
Nature/Quality of relationships: _____
_____

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Developmental History:

Developmental delays: _____
_____
_____

Educational/Occupational History:

Highest grade completed: _____
Current employer: _____
Position: _____

Legal History:

Number & Location of Arrests: _____
_____
What charges: _____
_____
Number & Location of Incarcerations: _____
_____
What charges: _____
_____

Strengths/Limitations:

Strengths List: _____
_____
Limitations List: _____
_____

Other important information:

_____
_____
_____
_____

I attest that the information provided in or attached to this questionnaire is complete, accurate, and true to the best of my knowledge.

_____
Client Signature mm/dd/yyyy

_____
Parent/Legal Guardian Signature (if client is a minor) mm/dd/yyyy

_____
Serenity in Motion, LLC Representative mm/dd/yyyy

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